100 MANAGEMENT OF DIVISION POLICIES AND PROCEDURES

REVISION DATE: 08/23/23

EFFECTIVE DATE: November 9, 2022

REFERENCES:A.R.S. 36-553, A.R.S. 41-3801

PURPOSE

To detail the expectations for the lifecycle of policy and procedures within the Department of Economic Security (DES) Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Medical Policy" means any Division policy that maintains requirements for Medical Services or Medical Supplies.
2. "Medical Services" means medical care and treatment provided by a Primary Care Provider (PCP), attending physician, or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
3. "Medical Supplies" means health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an

individual medical disability, illness or injury as specified in 42 CFR 440.70.

POLICY

A. The Division's Policy Unit shall be responsible for the development, revision, coordination, tracking, and maintenance of all official Division policies and procedures unless otherwise directed by the Division's Assistant Director.

B. DEVELOPMENT AND REVISION OF POLICY AND PROCEDURE

1. The Division's Policy Unit shall establish procedures that detail how Division staff initiate the development and revision of Division policy and procedure.
2. The Division's Policy Unit shall ensure that all new or revised policies and procedures are initiated only if they meet at least one of the following criteria:
    a. Aid the Division in maintaining compliance with:
        i. Applicable laws;
        ii. Regulations;
        iii. Contractual obligations;
        iv. AHCCCS policy; or

v. Written directives from the Arizona Governor or DES Director.

b. Ensure current business needs are being met; or

c. Clarify the document for the intended user or the public.

3. The Division's Policy Unit shall only accept requests for development or revision of Division policies and procedures from the following:

a. The administrator or manager identified as the owner of the document.

b. A member of the Division's Executive Leadership Team.

c. A proxy for the administrator or manager identified as the owner of the document that has been agreed to by the administrator or manager and the Division Policy Administrator.

d. The Division Policy Manager.

e. A Division Policy Specialist.

4. The Division's Policy Unit shall engage all functional areas identified as impacted by a policy or procedure being developed

or revised to provide input and work as part of a team for the final draft of the policy or procedure.

5. The Division Policy Specialist shall ensure that all policies and procedures adhere to the structure prescribed in the Division's Policy/Procedure Development and Format Manual.

C. APPROVAL OF POLICY

1. The following Division staff shall approve a new or revised policy in the following order after reviewing and being in agreement with the content and structure of the document:
   a. The owner, or the owner's proxy as described in (B)(3)(c) of this policy.
   b. The Division Policy Manager.
   c. The Division Policy Administrator.
   d. The Division Policy Review Team (PRT).
2. The Division Policy Specialist assigned to the development or revision of a policy shall:
   a. Coordinate discussion for policy needs with the identified policy owner and subject matter experts;

b. Engage subject matter experts as needed to address requested changes and questions from any individuals in (1) of this section;

c. Ensure consensus is reached by all subject matter experts involved in drafting or revision of the policy that the document is satisfactory in content and structure.

d. Ensure any changes instigated by any individuals in (1) of this section are approved by all other individuals in (1) of this section.

e. Prepare and send the draft policy to the Division Policy Manager and Division Policy Administrator for review and approval.

f. Route the draft policy:

    a. Back to the policy owner and any applicable subject matter experts to:

        i. Address any additional questions or recommendations; then

ii. Send back to the Division Policy Manager and Division Policy Administrator for final approval; or

b. To the PRT for consideration for approval.

3. The PRT shall review proposed policies for approval, determining whether the policy is:

a. Rejected;

b. Approved with changes; minor recommended changes agreed upon with the policy owner; or

c. Approved.

D. APPROVAL OF PROCEDURE

The Division Policy Specialist shall follow all steps in (C) of this document for the approval of procedures except (C)(1)(d).

E. PUBLIC COMMENTS

1. The PRT shall determine whether approved policies:

a. Post the following week to the Division's website and are then in effect; or

b. Require public comment if the policy:

i. Is a new Division policy; or

ii. Has substantive changes that may impact the public.

2. The Division Policy Manager shall ensure that the following actions are taken for policies going out for public comment:
   a. The unaltered version of the policy approved by the PRT with changes tracked in the document is used for the public comment period.
   b. Send a copy of the document for early notice of public comment to the following entities thirty days prior to posting the policy for public comment:
      i. The Arizona Developmental Disabilities Advisory Council;
      ii. The Independent Oversight Committees; and
      iii. Arizona Tribal entities.
   c. Thirty days after (2)(b) of this section, the policy is posted for a thirty day public comment period with a clear method for the public to submit comments to DDD.
3. The assigned Policy Specialist shall, at the conclusion of (2)(c) of this section, compile any received public comments and review the public comments with the subject matter experts and the

owner of the policy to determine if the policy requires changes based on the comments.

4. The assigned Policy Specialist shall, if substantive changes are made to the policy as a result of public comment or for any other reason following PRT approval, instigate the approval process described in (C) of this document.
5. The assigned Policy Specialist shall, if no substantive changes are made to the policy as a result of public comment or for any other reason following the PRT approval, inform the Policy Manager that the policy is ready to be posted.
6. The Division Policy Manager shall ensure each Quality Management and Medical Policy is signed by the Division's Chief Medical Officer prior to sending the policy to be posted.

F. POLICY AND PROCEDURE REVIEW

1. The Division Policy Manager shall establish and implement a process to ensure that each policy and procedure managed by the Division Policy Unit are reviewed on an annual basis by the following individuals to ensure the policy meets the current standards of the Division in terms of both content and structure:

a. The owner of the policy or their agreed to proxy; and

b. The Division Policy Specialist.

2. The Division Policy Manager shall, if a policy is determined to need changes based on the review in (1) of this section, ensure that the requirements in (B) of this document for the revision of a policy are instigated.

G. SHARING AND USE OF POLICY AND PROCEDURE

1. The Division shall only treat Division policies and procedures as official Division documents after the policies and procedures have completed the steps for approval designated in this policy.
2. The Division shall not represent or provide policies or procedures that have not completed the steps for approval designated in this policy as proof of compliance with requirements of contracts, regulations, laws, or oversight entities.

H. HISTORICAL MAINTENANCE OF POLICY AND PROCEDURE

The Division Policy Manager shall instigate and ensure the maintenance of a system to archive, track, and make available for research purposes past versions of policy and procedure.

101 MARKETING

REVISION DATE: 3/13/2024

REVIEW DATE: 6/19/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 101

PURPOSE

This policy sets forth requirements and restrictions for the Division of Developmental Disabilities' (Division) participation in Marketing activities related to the AHCCCS program.

DEFINITIONS

1. "Arizona Health Care Cost Containment System" or "AHCCCS" means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
2. "Administrative Services Subcontract/Subcontrator" or "AdSS" means An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims,

b. Pharmacy Benefit Manager (PMB),

c. Dental Benefit Manager,

d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),

e. Management Service Agreements,

f. Medicaid Accountable Care Organization (ACO),

g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and

h. CHP and DDD Subcontracted Health Plan.

A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

3. "Dual Eligible" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: a Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member

(a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

4. "Dual Eligible Special Needs Plan (D-SNP)" means a type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII) program covered health benefits and full Medicaid (Title XIX) program covered health benefits.
5. "Dual Marketing" means Marketing efforts specifically targeting a contractor's Member who is eligible for Medicare and Medicaid.
6. "Financial Sponsor" means any monies or in-kind contributions provided to an organization other than attendance fees or table fees, to help offset the cost of an event.
7. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a member enrolled with that Contractor of record.

8. "Marketing" means any communication from Contractors to a Member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Member to enroll with the Contractor, or to not enroll or disenroll with another Contractor's Medicaid product as specified in 42 CFR 438.104. Marketing does not include communication to any Member about a Qualified Health Plan, as specified in 45 CFR 155.20.
9. "Marketing-Health Message" means a slogan or statement on Marketing Materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.
10. "Marketing-Health Related" means an event that has a direct or indirect health care purpose, and/or it supports or contributes to any AHCCCS initiative or program goal. Giveaway items shall have a Health Message or a health care purpose to be considered health-related.
11. "Marketing Materials" means materials produced in any medium, by or on behalf of the Contractor that can reasonably be

interpreted as intended for Marketing purposes. This includes general audience materials such as general circulation brochures, Contractor's website and other materials that are designed, intended, or used to increase Contractor membership or establish a brand.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "Potential Member" means a Medicaid-eligible recipient who is not yet enrolled with a Contractor or a Member during Annual Enrollment Choice (AEC).
14. "Promotion" means any activity in which Marketing Materials are given away or displayed with the intent to increase the Contractor's membership.
15. "Social Networking Application" means web-based services or platforms, excluding the Contractor's State mandated website content, member portal, and provider portal, for online collaboration that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and

instant messaging services – collectively also referred to as social media (e.g., Facebook).

16. "Subcontractor" means

    a. A provider of health care who agrees to furnish covered services to Members.

    b. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

    c. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease, or leases of real property, to obtain space, supplies equipment or services provided under the AHCCCS agreement.

POLICY

A. MARKETING MATERIALS, GIVEAWAYS, EVENTS, SPONSORSHIPS, PRESS RELEASES AND DIVISION LOGO NAME USE

1. Materials and Giveaways

a. The Division shall use Member Marketing Materials during Marketing activities that have been previously approved as Member information under Division Operations Policy Manual Policy 404, only if they comply with the requirements of this policy.

b. The Division shall submit a description and image of Marketing Materials and Marketing items or giveaways for approval to AHCCCS as required under this policy and as specified in the AHCCCS Contract.

c. The Division shall not distribute approved materials and giveaways after two years from the date of approval.

d. The Division shall submit any changes or amendments to previously approved materials in advance to AHCCCS for approval.

e. The Division shall submit templates for flyers or posters that advertise regular meetings or events where only the dates and times of the events change.

f. The Division shall distribute approved templates for a period of two years from the date of approval.

d. The Division shall distribute health educational materials without prior AHCCCS approval if the materials are:

   i. Health-related; and

   ii. Developed based on information from an approved, recognized organization as listed on ACOM Policy 404, Attachment A.

e. The Division shall submit for approval materials considered Marketing Materials that include Division specific information related to the Division Integrated Contract.

f. The Division shall ensure that:

   i. The value of any Marketing item or giveaway to the general public by the Division must not exceed $15.00;

   ii. Giveaway items are health related, or if non health related, include a Health Message on the item;

   iii. All Marketing Materials identify the Division as a AHCCCS provider and are consistent with the requirements for information to Members described in the AHCCCS Contract and in Division policies;

iv. All Marketing Materials that have been produced by the Division and refer to contract services shall specify: "Contract services]are funded in part under contract with the State of Arizona Department of Economic Security/Division of Developmental Disabilities";

v. Marketing Materials that are distributed by the Division are distributed to its entire contracted GSA, exclusion of any particular group or class of Members would be considered to be a discriminatory Marketing practice; and subject to contract action.

g. The Division shall not market directly to Members eligible for the Division;

h. The Division shall not encourage or induce a Member to select a particular AdSS when completing the application and may not complete any portion of the application on behalf of the Potential Member.

2. Events

a. The Division shall participate in Health-Related Marketing events listed as pre-approved events in Section A.2.e. of this document, with the additional requirement that the pre-approved event also contains either:
   i. A health related; or
   ii. Health education component.

b. The Division shall submit a request for prior approval if the event is not specified as a pre-approved event in the contract for prior approval, containing the event name and date with the location and address.

c. The Division's participation in events shall be substantive; an unmanned booth with handouts is not acceptable.

d. The Division shall obtain approval from AHCCCS to attend pre-approved events when the following criteria apply:
   i. The Division pays sponsorship fees;
   ii. The Division donates benefits or items;
   iii. The Division plans to distribute materials not previously approved by AHCCCS within the last two years;

iv. Any event determined by the Division to not be in the best interest of the State of Arizona.

v. The Division is not certain if an event would qualify as pre-approved, in which case the Division shall submit a request for approval to AHCCCS prior to the event, including the name, date, location, and the address of the event.

e. The Division may attend the following pre-approved, health related events:

i. Back to School Events;

ii. College or University Events;

iii. DES Health or Resource Events if open to all AHCCCS plans;

iv. Women, Infants and Children (WIC) Health or Resource Events-if open to all AHCCCS plans;

v. Events where health education is a component;

vi. Jobs Fairs as specific in Contract and ACOM Policy 407;

vii. Community Center or Recreational Events;

viii. Community or Family Resource Events;

ix. Provider Events that the Contractor is contracted with;

x. Faith Based Events;

xi. Farmers Market Events;

xii. Health Educations Forum, community sponsored;

xiii. Safety Events;

xiv. Immunization Clinics;

xv. Senior Events;

xvi. Shopping Mall Events;

xvii. AHCCCS Contractor's Event that is created and sponsored by the Contractor for its own Members only.

f. The Division shall not participate in Marketing activities at the following events:

i. Events that are not health related or do not have a health education component;

iii. WIC Offices, except those listed on the approval list;

iv. Job Fairs, except those listed on the approval list;

v. County or State Fairs;

vi. Bi-national Health Events;

vii. Political Events;

viii. Pharmacy Events not open to all AdSSs;

ix. Swap Meets;

3. Sponsorships

The Division may participate as a Financial Sponsor of Health-Related Marketing events that are listed as pre-approved in Section A.2.e. in accordance with ACOM 101.

4. Press Releases

The Division may issue press releases or announcements about program innovations and events that promote the goals of the Division.

i. Press releases that do not include Division-specific information related to the Division Integrated Contract do not require prior AHCCCS approval.

ii. All other press releases must be submitted to AHCCCS for prior approval.

5. Division Logos and Name Inclusion

The Division shall be responsible for preventing misuse of the Division's name and logo.

i. Upon receiving AHCCCS approval for an event, the Division's logo can be included on event flyers or websites that are produced by hosting organizations without prior approval.

ii. The use of the Division's name or logo is prohibited for television advertising of the event.

iii. If the Division is a Financial Sponsor for the event, the event flyers or websites will require prior approval by AHCCCS.

B. RESTRICTIONS

The Division shall not participate in the following Marketing activities:

a. Television advertising;

b. Direct mail advertising;

c. Social Networking Applications;

d. Marketing of non-mandated services;

e. Utilization of the word "free" in reference to covered services;

f. Listing of providers in Marketing Materials who do not have signed contracts with the Division;

g. Inaccurate, misleading, confusing or negative information about AHCCCS; and any information that may defraud Members or the public; or

h. Discriminatory Marketing practices as specified in A.A.C. R9-22-501 et seq, A.A.C. R9-28-501 et seq, A.A.C. R9-31-501 et seq;.

C. DIVISION RESPONSIBILITIES

1. The Division shall report their Marketing costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any Marketing costs included in an allocation from a parent or other related corporation.
2. The Division shall review and revise all materials on a regular basis in order to reflect current practices.

3. The Division shall submit any changes or amendments to previously approved materials in advance to the Division for approval as indicated above.
4. The Division CEO or designee shall sign and submit to AHCCCS, ACOM 101, Attachment A, Marketing Attestation Statement as specified in Section F3, Contractor Chart of Deliverables, addressing the compliance of its plan with the requirements of this policy, including submissions from the AdSSs with Division submissions.
5. The Division shall submit to AHCCCS, ACOM 101, Attachment B, Marketing Activities Report, as specified in Section F3, Contractor Chart of Deliverables including the previous six months of Marketing activities in which the Division was a participant, including submissions from the AdSSs with Division submissions.

D. SUBMISSION REQUIREMENTS

1. The Division shall submit all Marketing Materials including, giveaways, event requests, sponsorships and press releases as individual requests for approval at least 21 days prior to

dissemination as specified in the AHCCCS Contract. Section F3, Contractor Chart of Deliverables.

a. Bulk submissions, including more than one event, sponsorship, press release, are not permitted with the exception of giveaway items.

b. Giveaway items shall be submitted for approval separately from any event or sponsorship submission and may consist of more than one giveaway.

c. All submissions shall be complete and include all corresponding documents.

2. The Division shall ensure the following criteria are completed when requesting an expedited review, when a 21-day notice is not possible:

a. Follow the submission requirements as noted above; and

b. Indicate the reason for the shortened timeframe.

3. The Division shall resubmit any Marketing Materials for review and approval if any substantive changes or modifications of previously approved materials have been made. Resubmissions require inclusion of:

a. Date the material was previously approved;

b. Reason for update; and

c. All clearly identified content revisions.

4. The Division may request a reconsideration of any AHCCCS decision by submitting a written request for reconsideration and following the submission requirements for Marketing Materials as specified in Contract. The Division may provide information in support of its request for reconsideration.

102 DDD ADMINISTRATIVE FORMS AND OTHER WRITTEN MATERIAL

EFFECTIVE DATE: April 26, 2023
REFERENCES: ACOM 404; DES 1-05-03

PURPOSE

To provide a consistent and structured framework for the development, approval, and storage of DDD Administrative Forms and other non-policy, non-procedure written material.

DEFINITIONS

1. "DDD Administrative Form" means any standardized form used only by employees of the Division of Developmental Disabilities (DDD) in the performance of their jobs.
2. "Job Aide" or "Desk Aide" means a tool or device that serves as a reminder or instruction on the implementation and use of a standard work or procedure..
3. "Standard Work" means a documented standardized and discrete process specific to a single work unit.

POLICY

A. DDD Administrative Forms

1. DDD staff shall not utilize or consider for official use any DDD Administrative Form that has not complied with DES 1-05-03, DES 1-05-03-01, and this policy.
2. DDD staff shall not utilize as proof of contract compliance, remedy of a corrective action plan, or in response to any legal or administrative request for official documents any DDD Administrative Form that has not met the requirements of DES 1-05-03, DES 1-05-03-01, and this policy.
3. DDD staff shall follow the process in DDD procedure POL-001-ALL Development or Revision of Division Administrative Forms for all new and revised DDD Administrative Forms.

B. Standard Work

1. DDD staff shall receive approval from the Executive Leader or their designee over the specific functional area prior to utilizing any new or revised Standard Work.
2. Each DDD functional area that utilizes Standard Work shall establish a standard methodology for internal approval of Standard Work and routing to the DDD Policy Administrator or their designee.

3. The DDD leader or their designee of each functional area shall ensure that all Standard Work approved under the specifications of this policy are sent to the DDD Policy Unit for storage and maintenance.

C. Job Aides and Desk Aides

1. DDD staff shall not use any Job Aide or Desk Aide as an official part of their job until it has been approved in writing by the Executive Leader or their designee of the associated functional area.
2. The Executive Leader of the associated functional area or their designee shall send all approved Job Aides and Desk Aides to the DES Policy Unit for storage.

D. Flyers, Pamphlets, and Posters

DDD employees shall reference DES policy DES 1-05-03 and associated DES procedures for the revision, creation, and maintenance of flyers, pamphlets, and posters.

E. Material Intended for Members

DDD staff shall comply with the stipulations of Arizona Health Care Cost Containment System ACOM 404 regarding written materials intended in whole or in part for the use of Members.

103 FRAUD, WASTE, AND ABUSE

REVISION DATE: 4/10/2024

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901, A.R.S. § 36-2918, A.R.S. § 36-2957, A.R.S. § 36-2903.01(K); A.A.C. R9-22-702; 42 CFR 455.101, 42 CFR 438.608, 42 CFR Part 438, Subpart H, 42 CFR 455, 42 CFR 455, Subpart A, 42 CFR 455, Subpart B, 42 CFR 455.2, 42 CFR 455.23, 42 CFR 455.101, 42 CFR 455.436; ACOM Policy 103, Attachment A; ACOM Policy 103, Attachment A-1; Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime; ACOM Policy 103, Attachment B; ACOM Policy 103, Attachment C; ACOM Policy 424; the Division Medical Policy 950, Credentialing and Recredentialing Processes; Attachment F3, Contractor Chart of Deliverables State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act.

PURPOSE

This Policy applies to the Division of Developmental Disabilities (Division). The purpose of this Policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged Fraud,

Waste, or Abuse involving Division program funds regardless of the source. This Policy also addresses additional responsibilities regarding regulatory compliance with program integrity, and programmatic requirements.

DEFINITIONS

1. "Abuse" means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program as outlined in 42 CFR 455.2.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including:
    a. Claims processing, including pharmacy claims
    b. Pharmacy Benefit Manager (PBM)
    c. Dental Benefit Manager

d. Credentialing, including those for only primary source verification through Credential Verification Organization [CVO]

e. Medicaid Accountable Care Organization (ACO)

f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner

g. CHP and the Division Subcontracted Health Plan

i. A person, individual or entity, who holds an Administrative Services Subcontract is an administrative services subcontractor.

ii. Providers are not administrative services subcontractors.

3. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a Provider as specified in 42 CFR 455.101.

4. "Contract" means the Division's contract with AHCCCS.

5. "Corporate Compliance Officer" means an individual located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be

a management official, available to all Division employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position. The Corporate Compliance Officer shall be an onsite management official who reports directly to the Contractor's Chief Executive Officer (CEO) and Board of Directors, if applicable. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract as specified in 42 CFR 438.608.

6. "Credible Allegation of Fraud" means the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis as specified in 42 CFR 455.2.
7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person, including any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

8. "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency as outlined in 42 CFR 455.101.
9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
10. "Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.
11. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. The Division shall:

1. Have in place internal controls, policies, and procedures to:

a. Prevent, detect, and report credible Fraud, Waste, and Abuse activities to AHCCCS-OIG.

b. Implement a suspension, termination, or exclusion of a provider from the Contractor's network of providers.

2. Have a Corporate Compliance Program that complies with the Division's contract with AHCCCS and all state and federal laws, including 42 CFR Part 438, Subpart H and is developed under the Contractor's corporate compliance plan including:

   a. Program integrity goals and objectives;

   b. Descriptions of internal and external controls employed by the Division to ensure compliance with State and Federal law; and

   c. The Division's corporate compliance activities, as outlined in ACOM 103.

3. Submit the Division's written Corporate Compliance Plan to AHCCCS-OIG annually as specified in the Contract.

4. Submit to AHCCCS-OIG an external audit plan/schedule and audit report of all individual provider audits using ACOM 103 Attachment C.

a. In each audit report, the Division shall include:

i. An objective, scope, estimated dollars at risk, current audit results, key audit findings, recommendations, corrective actions required, and conclusion;

ii. Copies of the report for each audit scheduled completed; and

iii. If an audit was not completed timely, include a reason why and a date when the audit will be completed.

b. The Division shall submit a minimum of 20 audits semiannually.

c. The Division shall submit follow-up audits on a separate ACOM 103 Attachment C and not count toward the required minimum audit numbers as stated in this subsection.

5. Submit complete, accurate, and current disclosure information, as described in 42 CFR Part 455, Subpart B and as specified in Contract, upon execution of a Contract with the State and upon

renewal of extension of the Contract utilizing Attachment A and Attachment A-1.

a. The Contractor shall ensure review of its response by its legal counsel prior to submitting disclosure information.

b. As specified in Contract, the Contractor shall submit all information electronically, without any exceptions.

c. AHCCCS/Office of Administrative Legal Services (OALS) and AHCCCS-OIG reviews the Contractor's submitted disclosure information for completeness and AHCCCS-OIG screens and confirms that persons listed in the submitted information are not excluded from participation in the Medicaid program.

6. Complete all information as specified in ACOM 103 Attachment A and Attachment A-1 to enable AHCCCS-OIG to confirm that persons with an ownership or control interest in the aDivision are not excluded from participation in the Medicaid program.

a. The Division shall obtain and disclose the information regarding the ownership and control interest of administrative services subcontractors.

b. The Division shall retain the results of the disclosure of ownership and control and the disclosure of information on persons convicted of crimes and report to AHCCCS-OIG.

c. The Division shall complete and submit an attestation as specified in ACOM 103 Attachment A along with the disclosure information described in this subsection and that the information provided is accurate, complete, and truthful.

d. Consistent with 42 CFR 457.990 and 42 CFR 438.606, the Division's Assistant Director (Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer) or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer shall sign the attestation.

e. The Division's failure to provide all complete and accurate disclosures and an attestation signed by an individual with appropriate authority may result in the withholding of payments under the Contract or the recovery, recoupment, or offset of any monies remitted without limitation.

7. Disclose, and require its administrative services subcontractors to disclose, to AHCCCS/OIG the identity of any employee or person with ownership or control interest who is excluded from participation in any federal healthcare programs.
8. Comply with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 457.1285, and 42 CFR 438.608(a)(6)].
9. As a condition for receiving payments, establish written policies, and ensure adequate training and ongoing education for all of its employees including management, Members, and any subcontractors or Agents of the Division regarding the following:
    a. Detailed information about the Federal False Claims Act;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal liability or penalties for false claims and statements; and
    d. The whistleblower protections under law.
10. Ensure adequate training addressing Fraud, Waste, or Abuse prevention, recognition and reporting, and encourage Division

employees, Members, and any subcontractors to report Fraud, Waste, or Abuse without fear of retaliation.

11. Ensure an internal reporting process relating to the reporting of Fraud, Waste, or Abuse that is well-defined is made known to all Division employees, Members, and any subcontractors.
12. Conduct research and proactively identify changes for program integrity that are relevant to the~~ir~~ corporate compliance program, and periodically review and revise the Fraud, Waste, or Abuse policies or guidance from the AHCCCS to reflect such changes due to rules, regulations, or new initiatives.
13. Regularly attend and participate in AHCCCS-OIG work group meetings.
14. Respond promptly and not later than 30 calendar days to requests for information from AHCCCS-OIG.
15. Cooperate with AHCCCS-OIG regarding any allegation of Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.

16. Have a method of verifying with Members that they received the services billed by Providers to identify potential service or claim Fraud.
17. Perform periodic audits through Member contact and report the results of these audits as specified in ACOM Policy 424.
18. Maintain compliance with all State and Federal laws and regulations related to Fraud, Waste, or Abuse even if not directly specified in this Policy.

B. REPORTING RESPONSIBILITIES

1. Fraud, Waste, and Abuse
    a. If the Division discovers, or is made aware, that an incident of alleged Fraud, Waste, or Abuse has occurred or is occurring, the Division shall report the incident to AHCCCS-OIG as specified in Contract and by completing and submitting the "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program" form available on the AHCCCS-OIG webpage, and attach all pertinent documentation that could assist AHCCCS in its investigation;

b. If the Division identifies an incident that warrants self-disclosure, the Division shall report incident within ten calendar days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage and attach all pertinent documentation that could assist AHCCCS in its investigation;

c. When the Division refers, or is aware that a subcontractor has referred, a case of alleged Fraud, Waste, or Abuse to AHCCCS-OIG, the Division shall take no action to recoup, offset, or act in any manner inconsistent with AHCCCS-OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, or impose a civil monetary penalty;

d. The Division shall conduct preliminary review work regarding a referral at the request of AHCCCS-OIG in order to expand the allegation and obtain documentation to support the investigation being conducted by AHCCCS-OIG;

e. The Division shall provide documentation requested by AHCCCS-OIG within 30 calendar days of the request;

f. The Division may receive notification from AHCCCS-OIG when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation;

g. The Division shall ensure proper disposition of any matters returned by AHCCCS-OIG as non-Medicaid Fraud, Waste, or Abuse in accordance with any applicable laws and contracts;

h. The Division shall adhere to the requirement that AHCCCS-OIG has the sole authority to handle and dispose of any matter involving Fraud, Waste or Abuse and assign to AHCCCS the right to recoup any amounts overpaid to a Provider as a result of Fraud, Waste or Abuse.

i. The Division shall forward anything of value that could be construed to represent the repayment of any amount expended due to Fraud, Waste or Abuse that is recovered to AHCCCS-OIG within 30 days of its receipt.

j. The Division shall ensure the requirements outlined in subsection (i) apply to any actions undertaken by the Division on behalf of a Contractor by a subcontractor, as specified in the AHCCCS Minimum Subcontractor Provisions (MSPs).

k. The Division shall relinquish all claims to any monies received by AHCCCS as a result of any program integrity efforts, including:

   i. Recovery of an overpayment;

   ii. Civil monetary penalties or assessments;

   iii. Civil settlements or judgments;

   iv. Criminal restitution;

   v. Collection by AHCCCS or indirectly on AHCCCS' behalf by the Office of the Attorney General; or

   vi. Other, as applicable.

l. The Division shall report to AHCCCS, as specified in Contract, and the Division Medical Policy 950, any credentialing denials including:

   i. That are the result of licensure issues;

ii. Quality of care concerns;

iii. Excluded, terminated, or otherwise sanctioned providers; or

iv. Alleged Fraud, Waste, or Abuse.

C. THE DIVISION'S RESPONSIBILITIES RELATED TO FRAUD, WASTE AND ABUSE

1. The Division shall:

   a. Process all referrals of allegations of suspected Member and provider Fraud, Waste, or Abuse.

   b. Oversee, monitor, and review all documents and functions as they relate to Fraud, Waste, and Abuse prevention, detection, and reporting.

   c. Maintain and monitor a tracking system of Fraud, Waste, and Abuse referrals.

   d. Ensure all Division employees, subcontractors, Providers, Agents, and Members receive adequate training and information regarding Fraud, Waste, and Abuse prevention, identification and reporting.

e. Assure Division employees, subcontractors, Providers, Agents, and Members that they can report Fraud, Waste, and Abuse without fear of retaliation.

f. Develop and maintain open channels of communication with AHCCCS-OIG, subcontractors, Providers, Agents, and Members to combat Fraud, Waste, and Abuse at all levels in the System.

g. Develop and maintain open channels of communication with DES-OIG in the prevention and detection of Fraud, Waste, and Abuse.

h. Make referrals to AHCCCS-OIG to investigate cases of potential Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.

i. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of Providers to ensure their compliance.

j. Ensure that the Division is in compliance with its federal obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion, and

Checks, and Criminal Convictions Checks, and all other federal requirements related to Provider Screening and Enrollment.

SUPPLEMENTAL INFORMATION

1. AHCCCS/Office of Inspector General (AHCCCS/OIG) is responsible for reviewing suspected incidents of fraud, waste, and/or abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with the authority or obligations vested in AHCCCS/OIG under State or Federal law, rule, regulations, or policies.

2. AUTHORITY

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations relating to Fraud, Waste, and Abuse involving the programs administered by AHCCCS. Pursuant to 42 CFR 455, Subpart A, and an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action.

AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

a. Pursuant to A.R.S. § 36-2918, AHCCCS-OIG has the authority to issue subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the AHCCCS-OIG.

b. Pursuant to A.R.S. §§ 36-2918 and 36-2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

c. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, AHCCCS-OIG is authorized to receive and share restricted

criminal justice information with other federal, state and local agencies.

d. Pursuant to federal law, AHCCCS-OIG shall suspend payments to providers where it determines that a credible allegation of fraud exists as specified in 42 CFR 455.23.

e. Pursuant to state and federal law, AHCCCS is required in certain circumstances, and in other circumstances it may, act to suspend, terminate, or exclude any person (individual or entity) from participation in the AHCCCS Program.

104 CONTINUITY OF OPERATIONS AND RECOVERY/EMERGENCY PREPAREDNESS PLAN

EFFECTIVE DATE: April 2, 2018

REFERENCES: 42 CFR 483.475, 28 CFR 0.85, 22 U.S.C 38 § 2656f (d)(2), ACOM 104, uslegal.com, fema.gov, dema.az.gov, cms.gov, and ready.gov

This policy outlines the Continuity of Operations and Recovery Plan, for the Division of Developmental Disabilities (DDD), including the Continuity of Operations and Recovery Plan/Emergency Preparedness Plan for the Division's Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), in conformance with CMS Final Rule 42 CFR 483.475, "Medicare and Medicaid Programs, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers;" and in conformance with ACOM 104.

The Division must be able to recover from any disruption in business operations as quickly as possible. This recovery can be accomplished by the activation of a Continuity of Operations and Recovery Plan that contains strategies for recovery. The Continuity of Operations and Recovery Plan is part of the federal government's Continuity of Operations Programs (COOP) requirements and the AHCCCS Contractor Operations Manual.

Division Responsibilities

The Division's Continuity of Operations and Recovery Plan assures AHCCCS that the provision of covered services will occur as stated in its contract [42 CFR 438.207 and 42 CFR 438.208]; and as stated in the CMS Emergency Preparedness requirements [42 CFR 483.475] for ICFs/IID. This policy outlines the policy and procedures requirement for 42 CFR 483.475 in conjunction with ACOM 104.

42 CFR 483.475 requires the following four elements in the ICF/IID Continuity of Operations and Recovery/Emergency Preparedness Plan.

- Risk Assessment and Planning – identifying potential risks to the entity using an "all hazards" approach
- Policies and Procedures – reflective of the risk assessment and to include training and testing procedures
- Communication Plan – communication within the entity and across local community health care providers, in conjunction with state and local public health departments
- Training and Testing – to be conducted annually for all staff

Continuity of Operations and Recovery Plan

A. The Division:

1. Reviews, tests, and updates the plan at least annually, to manage unexpected events and the threat of such occurrences, which may negatively and significantly impact business operations and the ability to deliver services to members
2. Ensures that all staff are trained at least annually and are familiar with the Plan and understand their respective roles

3. Designates a Continuity of Operations and Recovery Coordinator and furnishes AHCCCS with contact information as part of the Plan

4. Requires ICFs/IID to develop and maintain an Emergency Preparedness/Continuity of Operations and Recovery Plan

5. Maintains policies and procedures, as required by the Centers for Medicare and Medicaid Services (CMS), that address:

    a. The provision of subsistence needs for staff and members (food, water, medical and pharmaceutical supplies)

    b. Temperatures to protect client health and safety; emergency lighting; fire detection/extinguishing/alarms

    c. Sewage and waste disposal

    d. Tracking of members and staff during an emergency

    e. Evacuation and sheltering in place

    f. Availability of medical documentation

    g. The use of volunteers in an emergency

    h. Arrangements with other ICFs/IID and providers to receive members

    i. Other mitigation and response strategies as applicable

B. The Plan:

1. References local resources

2. Identifies:

    a. Key member priorities

    b. Key factors that could cause disruption

    c. Any additional priorities identified as critical, including communication systems (e.g., telephone, website, and email), providers' receipt of prior authorization approvals and denials, members receiving transportation, and timely claims payments

3. Contains:

    a. Specific timelines for resumption of services as well as the percentage of recovery at certain hours, and the key actions required meeting those timelines

    b. Planning and training for:

        i. Electronic/telephonic failure

ii. Complete loss of use of the main site location and any satellite offices in and out of state

iii. Loss of primary computer system/records

iv. Extreme weather conditions

v. Communication during a business disruption. (The name and phone number of a specific contact in the Division of Health Care Management, and AHCCCS Security at 602-417-4888 if disruption occurs outside of normal business hours.)

vi. Other mitigation and response strategies as applicable

c. Documented periodic testing and training at least annually

Resources

For more information on Continuity of Operations Planning and Emergency Preparedness, visit the websites of the following organizations:

- Federal Emergency Management Agency (FEMA) – fema.gov
- Arizona Department of Emergency and Military Affairs – dema.az.gov
- Centers for Medicare and Medicaid Services (CMS) – cms.gov
- Ready.gov.

108 SECURITY RULE COMPLIANCE

EFFECTIVE DATE: April 29, 2020
REFERENCES: 42 CFR 438.100(d) and 42 CFR 438.208(b)(4); 45 CFR Parts 160, 162, and 164; Section F3, Contractor Chart of Deliverables

This policy applies to the Division Developmental Disabilities (The Division).

Definitions

A. Breach - An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised. As stated in Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act issued in August 2009.

B. Health Insurance, Portability, and Accountability Act (HIPAA) - The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

C. HIPAA Privacy Rule - The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

D. HIPAA Security Rule - Established national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information.

E. Health Information Technology for Economic and Clinical Health Act (HITECH) -

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

F. Protected Health Information – Individually identifiable health information as described in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

- Created or received by a health care provider, health plan, employer, or health care clearinghouse.

- Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual.

Protected health information excludes information:

- In education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g

- In records described at 20 USC 1232g(a)(4)(B)(IV)

- In employment records held by a covered entity in its role as an employer

- Regarding a person who has been deceased for more than 50 years.

G. Information Technology (IT) Risk Analysis - The assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic protected health information held by a covered entity, and the likelihood of occurrence.

H. Information Technology (IT) Risk Management - The actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic protected health information and meeting the general security standards.

Data Security Audit

The Division must develop policies and procedures to ensure the privacy of protected health information, the security of electronic protected health information, and breach notification to members [42 CFR 438.100(d) and 42 CFR 438.208(b)(4)].

The Division must have a security audit performed by an independent third-party annually. If the Division performs in multiple AHCCCS lines of business, one comprehensive audit may be performed covering all systems for all lines of business or separate audits may be performed.

The audit must include, at a minimum, a review of the following:

1. Compliance with all security requirements as outlined in ACOM Policy 108, Attachment A, AHCCCS Security Rule Compliance Summary Checklist.

2. The Division policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Division's business practices, and the production processing systems. The Division's policies and procedures must include the requirements for the Breach Notification Rule.

Audits performed in the second and subsequent years of the contract will focus primarily on remediation of prior findings and system and policy changes identified since the prior audit.

AHCCCS Security Compliance Report

The Division must submit the AHCCCS Security Rule Compliance Report to AHCCCS annually as described in Section F3, Contractor Chart of Deliverables, by uploading the report to a secure AHCCCS Share Point site. The timeframe audited may be calendar year, fiscal year, or contract year and must be noted in the report. The report must include all findings detailing any issues and discrepancies between the AHCCCS Security Audit Checklist requirements and the Division's policies, practices and systems, and as necessary, a corrective action plan. In addition, the report must include written decisions regarding all addressable specifications.

The Division will verify that the required audit has been completed and the approved corrective action plan is in place and implemented as part of Operational Reviews.

The Division does not intend to release detailed audit reviews; however may, at its discretion, release a summary level of results.

AHCCCS Security Rule Compliance Checklist

A. Instructions

The AHCCCS Security Rule Compliance Checklist, located in the AHCCCS Operations Manual, identifies security rule requirements for administrative, physical, and technical safeguards. The Compliance Checklist must be signed and dated by the Chief Executive Officer or his/her designee verifying the information and must be submitted with the annual report.

B. Implementation Specifications

1. Required Specifications

If an implementation specification is identified as "required" (indicated with an "R" on the checklist), the specification must be implemented.

Addressable Specification: The concept of "addressable implementation specifications" was developed to provide covered entities additional flexibility with respect to compliance with the security standards. Addressable implementation specifications are indicated with an "A" on the checklist.

In meeting standards that contain addressable implementation specifications, a covered entity must do one of the following for each addressable specification:

a. Implement the addressable implementation specifications.

b. Implement one or more alternative security measures to accomplish the same purpose.

c. Not implement either an addressable implementation specification or an alternative.

The covered entity must decide whether a given addressable implementation specification is a reasonable and appropriate security measure to apply within its particular security framework. For example, a covered entity must implement an addressable implementation specification if it is reasonable and appropriate to do so, and must implement an equivalent alternative if the addressable implementation specification is unreasonable and inappropriate, and there is a reasonable and appropriate alternative. This decision will depend on a variety of factors, such as, among others, the entity's risk analysis, risk mitigation strategy, what security measures are already in place, and the cost of implementation.

The decisions that a covered entity makes regarding addressable specifications must be documented in writing. The written documentation should include the factors considered as well as the results of the risk assessment on which the decision was based.

2. IT Risk Analysis

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(A), for Risk Analysis, requires a covered entity to, *"conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity."*

IT Risk analysis is the assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic PHI held by a covered entity and the likelihood of occurrence. The risk analysis may include taking inventory of all systems and applications that are used to access and house data and classifying them by level of risk. A thorough and accurate risk analysis would consider all relevant losses that would be expected if the security measures were not in place, including loss or damage of data, corrupted data systems, and anticipated ramifications of such losses or damage.

3. IT Risk Management

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(B), for IT Risk Management, requires a covered entity to *"implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR. 164.306(a) [(the General Requirements of the Security Rule)]."* IT Risk management is the actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic PHI and to meet the general security standards.

4. Compliance Status

If the covered entity complies with the requirement, insert a “C” in the column. If the requirement is not met, insert “NC” for non-compliant.

5. Compliance Documentation

List policies, procedures, and processes used to determine compliance with the Implementation Specification.

109 INSTITUTION FOR MENTAL DISEASE 15 DAY LIMIT

REVISION DATE: 10/1/2021, 2/24/2021, 3/26/2020
EFFECTIVE DATE: March 25, 2020
REFERENCES: 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

Purpose

This Policy applies to the Division of Developmental Disabilities (the Division) covered in the DDD Tribal Health Program (THP) population, which is managed as a Fee-For-Service (FFS) program along with the Division's oversight of each Administrative Services Subcontractor (AdSS). This policy establishes requirements the Division will follow for compliance with managed care regulation 42 CFR 438.6(e), "Payments to MCOs for and Prepaid Inpatient Health Plans (PIHPs) for enrollees that are a patient in an institution for mental disease."

Definitions

A. Day - A calendar day unless otherwise specified.

B. Institution - An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services, to four or more persons unrelated to the proprietor.

C. Institution for Mental Disease (IMD) - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an institution for a mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010].

D. IMD Stay - The total number of calendar days of an inpatient stay in an institution for mental disease beginning with the admission date through discharge, but not including the date of discharge unless the member expires.

Policy

Medically necessary IMD Stays are covered for individuals under the age of 21 (except as noted below under "Members Turning 21 or 65 Years of Age") and for adults 65 years of age and older. For adult members age 21 and older but under the age of 65 (referred to in this policy as "adult member age 21-64"), coverage is subject to the limitations and requirements outlined in this policy. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services or settings at 42 CFR 438.3(e)(2)(i) through (iii).

In accordance with 42 CFR 438.6(e), IMD Stays are covered for adult members age 21-64, so long as the IMD Stay is no longer than 15 cumulative days during a calendar month.

The following provider types are considered to be IMDs subject to the limitations and requirements outlined in this policy:

A. B1-Residential Treatment CTR-Secure (17+Beds)

B. B3-Residential Treatment Center-Non-Secure

C. B6-Subacute Facility (17+Beds)

D. 71-Psychiatric Hospital

Requirements

A. Members remain enrolled and eligible for all medically necessary services during the entire IMD Stay whether the stay exceeds 15 cumulative days during a calendar month. The Division is responsible for the payment of these services.

B. For any IMD stay that exceeds 15 days, neither the IMD Stay nor any other medically necessary services provided during the length of that IMD Stay may be paid with Title XIX funding, including administrative funding for Title XIX services.

C. The Division, when responsible for behavioral health services, shall complete and submit to AHCCCS the AHCCCS Contractors Operational Manual *Policy 109 Attachment A – IMD Placement Exceeding 15 days* to the Division, within one business day of identification of an IMD Stay greater than 15 days.

D. Submission of Attachment A will result in a change to the member's physical and behavioral health enrollment/assignment with the Division resulting in an adjustment to the Capitation.

E. The Division shall continue to submit encounters for all medically necessary services, including the IMD Stay, regardless of the length of the IMD Stay, and regardless if AHCCCS recoups the capitation payment for that month; that is, the Division is not permitted to recoup payments to providers. AHCCCS will use encounters to audit Division compliance with this policy. Encounters related to the IMD Stay will not be considered in the reconciliation and reinsurance processes.

F. The Division must maintain a network of providers adequate to provide members with adequate access to behavioral health services and ensure the member receives care in the setting most appropriate for the member's needs.

Capitation Recoupment

A. When an adult member's IMD Stay is longer than 15 cumulative days during the calendar month, AHCCCS will recoup the Division's entire monthly capitation payment for that member.

B. The change to a member's enrollment/assignment to non-Capitated will trigger the recoupment.

C. When two different entities are responsible for physical health services and behavioral health services for the member, AHCCCS must recoup the entire monthly capitation payment from both entities.

D. The capitation recoupment will occur whether the Division pays the IMD.

E. This recoupment applies whether the member is dual eligible or the member has third party insurance coverage.

F. The Division will be notified of the contract type change/recoupment via the 834 and 820 files from AHCCCS.

G. After funds have been recouped, AHCCCS will make a capitation payment to the Division equal to a pro-rated amount of the monthly capitation payment for each day the member is not in an IMD during the calendar month.

Members Turning 21 Or 65 Years of Age

A. The IMD restriction does not apply for a member admitted prior to age 21 and turns 21 during the IMD Stay until the member turns 22 years of age during the IMD Stay. The Division is not required to report an IMD Stay greater than 15 days when the member is admitted prior to age 21 even if the member turns 21 during the same IMD Stay as long as the member is discharged prior to age 22.

B. For members who turn age 65 during an IMD Stay, all the days of the IMD Stay while the member is age 64 must be counted against the 15-day limit, and all the IMD Stay days when the member is 65 must not be counted against the limit.

The Division must report an IMD Stay greater than 15 days when the member is admitted prior to age 65 even if the member turns 65 during the same IMD Stay. After funds have been recouped, AHCCCS will make a capitation payment to the Division equal to a pro-rated amount of the monthly capitation payment for each day the member is age 65 or older during the IMD Stay.

110 MENTAL HEALTH PARITY

REVISION DATES: 2/16/22, 3/24/21
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR Part 457 and 42 CFR Part 438

PURPOSE

This Policy applies to the Division's internal practices which could impact Mental Health Parity and oversight of each Administrative Services Subcontractor (AdSS) whose contract includes this requirement. This Policy outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 42 CFR Part 457 and 42 CFR Part 438.

AHCCCS will facilitate Mental Health Parity requirements for Tribal Health Program members who are receiving part of their services through the Division.

DEFINITIONS

Aggregate Lifetime Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP).

Annual Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid in a fiscal year 12-month period under a MCO, PIHP, or PAHP.

Benefit Package - Benefits provided to a specific population group or targeted residents (e.g., individuals determined to have a serious mental illness [SMI]) regardless of the Health Care Delivery System.

Cumulative Financial Requirements - Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.

Health Care Delivery System - The health care delivery system refers to the structure and organization of covered services and benefit packages available to AdSS members. Delivery systems can be fully integrated (all covered services administered by a single AdSS) or partially integrated (Members enrolled with an AdSS may receive covered services by multiple AdSS or via fee-for-service arrangements).

Medical/Surgical Benefits (M/S) - Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. Medical/surgical benefits include long-term care services.

Mental Health Benefits - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the

State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

Substance Use Disorder Benefits - Items or services for substance use disorders, as defined by the State and in accordance with applicable Federal and State law. Any disorder defined by the State as being or not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include long-term care services.

Treatment Limitations - Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

POLICY

A. MHPAEA Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the MHPAEA final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to Mental Health/Substance Use Disorder (MH/SUD) benefits than to Medical/Surgical (M/S) benefits. MHPAEA specifically:

1. Prohibits the application of annual or lifetime dollar limits to MH/SUD benefits unless aggregated dollar limits apply to at least one third of medical benefits;

2. Prohibits the application of financial requirements (e.g., copays) and Quantitative Treatment Limitations (QTLs) (e.g., day or visit limits) on MH/SUD benefits that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in that same classification; and

3. Prohibits the application of Non-Quantitative Treatment Limits (NQTLs) (e.g., prior authorization) on MH/SUD benefits in any classification unless the NQTL, as written and in operation, is applied to the MH/SUD benefits comparably and no more stringently than to M/S benefits in the same classification.

B. Mental Health Parity Analysis Requirements

The Division is responsible for performing the initial and ongoing parity analyses. MH/SUD or M/S benefits are provided to members through the AdSS. The AdSS are responsible for completing initial and ongoing parity analyses and submitting them to the Division. The Division is responsible for ensuring compliance within the Division and for all AdSS.

1. Parity requirements apply to all MH/SUD benefits provided to members.

2. The parity analysis must be conducted and assessed at least annually and ongoing for events warranting a parity analysis as described below.

3. The parity analysis must be conducted for each benefit package regardless of Health Care Delivery System.

   a. The benefit package includes the covered services to ALTCS eligible members.

   b. A benefit package includes M/S and MH/SUD benefits, including long-term care benefits.

C. Standard Parity Requirements

1. Benefit Packages

   Division benefit packages and Health Care Delivery Systems are defined as covered services available to children and adult members who are enrolled with the Division and ALTCS eligible, and Medicare cost sharing. Members up to the age of 21 are designated as children for the purpose of the benefit package.

   The Division shall adhere to all applicable established benefit packages and covered services when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

2. Defining MH/SUD and M/S Benefits

   MH/SUD benefits are items and services for MH/SUD conditions regardless of the type of AdSS or type of provider that delivers the item/service. The Division defines MH/SUD and M/S conditions using the ICD-10-Clincial Modification (ICD- 10). For purposes of parity, MH and SUDs are those conditions in ICD-10, chapter 5, “Mental, Behavioral and Neurodevelopmental Disorders,” sub-chapters 2-7 and 10- 11.

   a. Subchapter 1, “Mental Disorders Due to Known Physiological Conditions,” is excluded from the MH condition definition (and included in the M/S condition definition) because the physiological condition is primary for these diagnostic codes; and

   b. Similarly, sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the MH condition definition (and included in the M/S condition definition) because these are neurodevelopmental conditions, which are separate and distinct from mental and behavioral conditions, as indicated by the chapter title.

   The Division uses these definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, the Division applies the defined classifications outlined below.

In order to conduct the analysis, each service is assigned to one of four classifications: inpatient, outpatient, emergency care, and prescription drug. The Division shall apply the established benefit mapping when conducting the parity analysis. Refer to AHCCCS Contractor Operations Manual (ACOM), Chapter 100, Policy 110, Attachment A (AZ Parity Summary Benefit Package Mapping) for the benefit mapping. Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

a. Inpatient: Includes all covered services or items provided to a member in a setting that requires an overnight stay including behavioral health placement settings;

b. Outpatient: Includes all covered services or items provided to a member in a setting that does not require an overnight stay, which does not otherwise meet the definition of inpatient, prescription drug, or emergency care services;

c. Emergency care: Includes all covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting; and

d. Prescription drugs: Covered medication, drugs, and associated supplies and services that require a prescription to be dispensed, which includes drugs claimed using the NCPDP claim forms.

Parity requirements for financial requirements, quantitative treatment limits, and non-quantitative treatment limits apply by classification (e.g., as inpatient, outpatient, emergency, and pharmacy).

The Division applies the defined classifications when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

4. Testing MH/SUD Financial Requirements, Quantitative Limits, Annual Dollar Limits, and Non-Quantitative Treatment Limits

a. When applicable, the Division shall conduct limit testing as part of the initial parity analysis and shall re-assess compliance when changes may impact parity compliance. Testing limits includes:

i. Identifying and evaluating financial requirements and quantitative treatment limits using a 2-part, claims-based test (if applicable). The Division determined that the 2-part, claims-based test is not necessary when performing or overseeing the initial mental health parity.

ii. Identifying and testing aggregate lifetime and annual dollar limits (if applicable) using a multi-part claims-based test. The Division did not identify any of these limits applicable to any MH/SUD services and as a result, no review or testing is necessary.

iii. Identifying NQTLs and applying the NQTL information-based test to each NQTL.

b. Quantitative treatment limits are numerical limits on benefits based on the frequency of treatment, number of days, days of coverage, days in a waiting period, or similar limits on treatment scope or duration. In accordance with this Policy, the Division shall not apply quantitative treatment limits to any MH/SUD services in any classification in any benefit package, with the exception that hour limits currently applied to respite services (600 hours/year) and visit limits (15 visits per Contract Year) currently applied to rehabilitative occupational therapy services in the outpatient classification are permissible under the parity requirements.

c. NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits.

i. Examples of NQTLs published in the Final MHPAEA Rule include:

1) Medical management standards (e.g., medical necessity criteria and processes or experimental/investigational determinations);

2) Prescription drug formulary;

3) Admission standards for provider network;

4) Standards for accessing out-of-network providers;

5) Provider reimbursement rates (including methodology);

6) Restrictions based on the location, facility type, or provider specialty;

7) Fail-first policies or step therapy protocols; and

8) Exclusions based on failure to complete a course of treatment.

ii. AHCCCS identified the following NQTLs as part of the initial MHPAEA compliance determination:

1) Utilization management NQTLs,

2) Medical necessity NQTLs,

3) Documentation requirements NQTLS, and

4) Out-of-network/geographic area coverage NQTLs.

iii. The Division shall not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the Division as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification, and

iv. Once NQTLs are identified, the Division shall collect and analyze information about the processes, strategies, evidentiary standards, and other factors applicable to each NQTL, in writing and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis by the Division or AdSS

1. The Division is responsible for administering a fully integrated contract and shall perform a parity analysis when there is a change in the Division's operations that may impact parity compliance including but not limited to:

   a. Changes to Financial Requirements (FRs) or QTLs;

   b. Changes to Benefit Packages, utilization requirements, covered services, or service delivery structures (i.e., change in the subcontractors performing administrative functions);

   c. Substantive changes to policies or procedures of the Division (or subcontractors performing administrative functions on the Division's behalf) that impact benefit coverage, access to care for provider contracting. The Division shall track, ongoing, all policy changes that are approved by the Division's Policy Review Team and review each for potential Mental Health Parity concerns. If a potential Mental Health Parity concern is identified, the Mental Health Parity Subcommittee will be convened to review the issues and determine the actions needed for correction.

2. If the Division identifies any changes or deficiencies noted in the above, the Division is required to attach the Mental Health Parity analysis for those FR/QTLs and NQTLs impacted by the changes. Utilizing ACOM Policy 110 Attachment C and shall include:

   a. Any actual Parity issues identified,

   b. The FR/QTLs or NQTLs associated with the Mental Health Parity concern,

c. The applicable Benefit Package(s) and affected classification(s), and

d. The nature of the Mental Health Parity compliance issue and the actions taken to address the parity issue.

3. When the Division contracts with any AdSS that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package the AdSS shall perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis shall be submitted to the Division as specified in the AdSS Contract with the Division. The Division shall ensure AdSS compliance with this policy and results of the analysis shall be submitted to AHCCCS as requested by AHCCCS.

4. The AdSS shall report as specified in the AdSS Contract with the Division, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation and applied no more stringently to MH/SUD benefits than for M/S benefits. The Division shall review reports received from the AdSS to ensure AdSS compliance.

5. The Division shall also report as specified in the AHCCCS Contract, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities, as well as the Division's oversight of the AdSS, for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation applied no more stringently to MH/SUD Benefits than for M/S Benefits.

6. In the event the Division or the AdSS complete a contract modification, amendment, novation, or other legal act changes which limits, or impacts compliance with the mental health parity requirement, the Division and/or the AdSS shall conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the Division and/or the AdSS must provide documentation of how the parity requirement is met, with the submission of the contract change, and how sustained compliance will be achieved. The Division and/or the AdSS must certify compliance with parity requirements prior to the effective date of the contract changes.

7. The AdSS shall report mental health parity deficiencies as specified in the AdSS Contract with the Division and develop a corrective action plan to be in compliance within the same quarter as the submission. The Division shall review the corrective action plan submitted by the AdSS and monitor to ensure compliance.

8. The Division shall report mental health parity deficiencies as specified in the AHCCCS Contract and develop a corrective action plan to be in compliance within the same quarter as the submission.

9. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the parity analysis by the Division and each AdSS.

10. The Division uses any data collection and documentation template for the parity analysis; however, the following elements must be clearly documented:

a. Methodology, processes, strategies, evidentiary standards, and other factors applied;

b. All financial requirements, AL/ADLs, QTLs and identified NQTLs AdSSs must minimally report NQTL analysis results for prior authorization, concurrent review, medical necessity, outlier, documentation, and out of area criteria, but must also assess and document for the presence of other potential NQTLs:

i. Monitoring mechanisms and aggregated results as applicable (e.g., denial rates);

ii. Findings;

iii. Components of the analysis that are determined to be non-compliant with parity along with a detailed plan to resolve identified deficiencies; and

iv. The Division and each AdSS shall analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

11. If there have been no changes that affect the Division's benefit package, utilization, or Health Care Delivery Systems, the Division shall submit an annual attestation (AHCCCS Contractor's Operations Manual, Policy 110, Attachment B - Mental Health Parity Attestation Statement) certifying ongoing compliance with mental health parity requirements as specified in AHCCCS Contract. These same attachments are also required from each AdSS for delivery to the Division as appropriate.

12. The Division and each AdSS shall make available upon request to members and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. The Division and each AdSS shall also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

13. The Division and each AdSS may be required to respond to inquiries from the Division, AHCCCS or an AHCCCS contracted consultant. Inquiries may include policies and procedures requiring review to determine compliance with mental health parity regulations.

E. Division Oversight of AdSS Mental Health Parity

1. Each AdSS is required to send their Mental Health Parity reports to the Division for review. This will occur at a minimum annually and when changes are made as addressed in this policy. The Division shall review the reports submitted by the AdSS to ensure AdSS compliance.

2. The Division shall review AdSS compliance with Mental Health Parity analyses, methodology, processes, and other related functions during its annual operational review of the AdSS, including but not limited to:

a. The AdSS policies and procedures for monitoring compliance with Mental Health Parity.

b. The AdSS completed analysis demonstrating compliance with Mental Health Parity as outlined in this policy.

c. The AdSS' process when a deficiency is identified and the plan of how the AdSS will come back into compliance.

203 CLAIMS PROCESSING

REVISION DATE: 11/8/2023, 3/30/2022, 10/01/2019

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 C.F.R. §§ 160, 162, and 164; 42 C.F.R. § 438.242(a)-(b); 42 C.F.R. § 447.45(d)(5)-(6); 42 § C.F.R. 447.46; 42 C.F.R. § 457.1233(d); A.R.S. § 36-2903.01; A.R.S. § 36-2903.01(G); A.R.S. § 36-2904; A.R.S. § 36-2943(D); ACOM 201; ACOM 203; ACOM 412; ACOM 434; AHCCCS Contract

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division of Developmental Disabilities (the Division).

DEFINITIONS

1. "Clean Claim" means a claim that may be processed without obtaining additional information from the Provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
2. "Member" means the same as "client" as defined by A.R.S. § 36-551.

3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.
4. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
5. "Receipt Date" means the day a claim is received at the Division's specified claim mailing address or received through direct electronic submission to the Division's electronic claims processing system.

POLICY

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The Division shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. The Division shall ensure that claims processes and systems generate information in the following areas:
    a. Service utilization;
    b. Claim disputes;

c. Member grievances and appeals; and

d. Disenrollment for reasons other than loss of Medicaid eligibility.

3. The Division shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:

a. The Division's subcontract;

b. The Division's Provider manual;

c. The Division's website; or

d. Other Provider platforms.

4. The Division shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date electronically received by the Division.

5. The Division shall recognize the paid date of the claim as the date on the check or other form of payment.

B. CLAIM TIMELY FILING

1. The Division shall, unless a contract specifies otherwise, adjudicate claims for each form type as follows:

a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and

b. 99% within 60 days of receipt of the Clean Claim.

2. The Division shall not pay the following claims as specified in A.R.S. § 36-2904(G):

a. Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or

b. Claims submitted as Clean Claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

3. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization (MCO), when one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

4. If the Provider submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:

a. 60 days from the date of the recoupment;

b. 12 months from the date of service; or

c. 12 months from the date that eligibility is posted;

whichever date is later.

5. The Division shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes stated in item 3 of this section.

6. The Division shall process a claim for payment if the AHCCCS Director's decision reverses a decision to deny, limit, or delay authorization of services, and the disputed services were received while an appeal was pending.

a. The Provider shall have 90 days from the date of the reversed decision to submit a Clean Claim to the Division for payment.

b. The Division shall not deny claims for untimely filing if the claims are submitted within 90 days from the date of the reversed decision.

c. Additionally, the Division shall not deny claims submitted as a result of a reversed decision because a Member failed

to request continuation of services during the appeal or hearing process.

7. The Division shall adhere to the claim payment requirements in this policy for both contracted and non-contracted Providers.

C. DISCOUNTS

1. The Division shall, unless a subcontract specifies otherwise, apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the Clean Claim was received (A.R.S. § 36-2903.01(G)).
2. The Division shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS

1. The Division, in the absence of a subcontract specifying other late payment terms, shall pay interest on late payments.
2. The Division shall pay interest on late payments for hospital Clean Claims as follows:

a. The Division shall pay slow payment penalties or interest on payments made after 60 days of receipt of the Clean Claim.

b. The Division shall pay interest at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. § 36-2903.01).

c. The Division shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The Division shall adjudicate a claim for authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS Provider, or a home and community based (HCBS) ALTCS Provider within 30 calendar days after receipt by the Division.

4. The Division shall pay interest on payments made after 30 days of receipt of the Clean Claim for licensed skilled nursing facility, assisted living ALTCS, or HCBS ALTCS as follows:

a. At the rate of 1% per month; and

b. Prorated on a daily basis from the date the Clean Claim is received until the date of payment.

5. The Division shall, for non-hospital Clean Claims, pay interest on payments made after 45 days of receipt of the Clean Claim as follows:
   a. At the rate of 10% per annum; and
   b. Prorated daily from the 46th day until the date of payment.
6. The Division shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission,not the claim dispute.
7. The Division shall report the interest paid as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The Division shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or the assigned representative interested in and capable of electronic submission of:
   a. Eligibility verifications;

b. Claims;

c. Claims status verifications; and

d. Prior authorization requests; or

e. The receipt of electronic remittance.

2. The Division shall make claim payments via electronic funds transfer (EFT).

3. The Division shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The Division shall generate an electronic remittance advice related to the payments or denials to Providers that include at a minimum:

a. The reason(s) for denials and adjustments;

b. A detailed explanation or description of all denials; payments, and adjustments;

c. The amount billed;

d. The amount paid;

e. Application of coordination of benefits COB and copays;

f. Providers rights for claim disputes;

g. Detailed instructions and timeframes for the submission of claims disputes and corrected claims; and

h. A link or supplemental file where claims dispute or corrected claims submission information is explained.

2. The Division shall send the related remittance advice with the payment, unless the payment is made by EFT.

3. The Division shall send any remittance advice related to an EFT to the Provider no later than the date of the EFT.

G. GENERAL CLAIMS PROCESSING REQUIREMENTS

1. The Division shall use nationally recognized methodologies to correctly pay claims including:

a. Medicaid National Correct Coding Initiative for professional, ambulatory surgery centers, and outpatient services;

b. Multiple procedure or surgical reductions; and

c. Global day evaluation and management bundling standards.

2. The Division’s claims payment system shall assess and apply data-related edits, including:

a. Benefit package variations;

b. Timeliness standards;

c. Data accuracy;

d. Adherence to AHCCCS policy;

d. Provider qualifications,

e. Member eligibility and enrollment; and

f. Over-utilization standards.

3. The Division shall, if a claim dispute is overturned in full or in part, reprocess and pay the claim(s):

   a. In a manner consistent with the decision; and

   b. Within 15 business days of the decision.

4. The Division's claims payment system shall not require a recoupment of a previously paid amount when:

   a. The Provider's claim is adjusted for data correction; excluding payment to a wrong Provider; or

   b. An additional payment is made.

5. The Division shall submit encounters in accordance with AHCCCS' standards and thresholds.

6. The Division shall adhere to the following requirements when processing claims:

a. Medicare cost sharing for Members covered by Medicare and Medicaid;

b. COB and third party liability requirements per the AHCCCS Contract and ACOM 434;

c. Claims recoupments and refunds requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS Claims Dashboard Reporting Guide; and

d. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 C.F.R. §§ Parts 160, 162, and 164.

7. The Division, when cost avoiding a claim, shall apply the following payment provisions:

a. Claims from Providers contracted with the Division: The Division shall pay the difference between the contracted rate and the primary insurance paid amount, not to exceed the Division’s contracted rate.

b. Claims from Providers not contracted with the Division: The Division shall pay the difference between the AHCCCS capped-fee-for-service rate and the primary insurance paid

amount, not to exceed the AHCCCS capped-fee-for claims processing by Administrative Services Subcontractors (AdSS) Contractors.

H. CLAIMS SYSTEM AUDITS

1. The Division shall regularly audit payments to contracted and non-contracted Providers to verify that:
   a. Payments are accurate per the Provider contract terms or letter of authorization; and
   b. Emergency services Providers are paid at the current AHCCCS fee-for-service rate for non-contracted Providers.
2. The Division shall ensure audit reports are shared with the Business Operations Administrator, Business Operations Deputy Administrator, and Corporate Compliance.
3. The Division shall correct deficiencies noted in claims system audit reports and issue corrective action plans as applicable to contracted and non-contracted Providers.
4. The Division shall audit three months of claims data for both contracted and non-contracted Providers.

5. The Division shall utilize HHS-OIG RAT-STATS to generate statistically significant random samples for claims systems audit reviews.
6. The Division shall conduct the interest paid audit in January, April, July, and October.
7. The Division shall conduct the negotiated rate audit in February, May, August, and November.
8. The Division shall conduct the override audit in March, June, September, and December.
9. The Division shall regularly audit contracted Providers, both large groups and individual practitioners:
    a. At least once every five-year period;
    b. Any time a contract change is initiated; and
    c. Within six months of onboarding new Providers
10. The Division and DES-Internal Audit Administration (DES-IAA) shall adhere to the AHCCCS approved Corporate Compliance audit schedule for contracted Providers.
11. DES-IAA shall also conduct Provider audits based upon corrective action plans initiated by the Division.

12. The Division shall conduct annual audits for compliance with the Deficit Reduction Act of 2005.
13. The Division shall require contracted Providers that receive at least five million dollars in Medicaid payments annually to establish written policies for all employees.
    a. The Division shall require contracted Providers to submit the following policy documentation that includes detailed information of the following:
        i. Federal False Claims Act;
        ii. Remedies for false claims and statements;
        iii. Any state laws pertaining to civil or criminal penalties for false claims and statements;
        iv. Whistleblower protections under Federal False Claims Act and state laws; and
        v. Role of such laws in preventing and detecting fraud, waste and abuse.
    b. Organization compliance program
    c. Employee handbook, with specific discussion of:
        i. The State and federal laws referenced above;

ii. The rights of employees to be protected as whistleblowers; and

iii. The entity's policies and procedures for detecting fraud, waste, and abuse.

I. ADSS CLAIMS PROCESSING

The Division shall contract with health plans and delegate the processing of acute care claims. Refer to the AdSS Operations Manual, 203 Claims Processing policy for further details.

205 GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT REQUIREMENTS FOR NON-CONTRACTED PROVIDERS

EFFECTIVE DATE: 11/6/2019

REFERENCES: 42 CFR 414.605, A.R.S. §36-2201, 9 A.A.C. 22, Article 211, A.A.C. R9-25-101(18), 42 CFR 438.114(a), A.R.S. §36-2202, A.R.S. §36-2204, and A.R.S. §36-2212, 9 A.A.C. 22, A.R.S. § 36-2239(H), and AMPM Policy 310-BB.

Purpose

To provide ground ambulance transportation reimbursement requirements. It is limited to the Division of Developmental Disabilities (the Division) and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Definitions

A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS, level 1 (**ALS1**) as transportation by ground ambulance vehicle, medically necessary supplies and services, either an ALS assessment by ALS personnel or provision of at least one ALS intervention. Advanced life support, level 2 (**ALS2**) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion,
- Endotracheal intubation,
- Central venous line,
- Cardiac pacing,
- Chest decompression,
- Surgical airway, or
- Intraosseous line.

B. Ambulance - Ambulance as defined in A.R.S. §36-2201.

C. Basic Life Support (BLS) - 42 CFR 414.605, describes BLS as transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least one of the staff members must be certified, at a minimum, as an emergency medical technician-basic (EMT-Basic) by the State of local authority where the services are furnished and be legally authorized to operation all lifesaving and life-sustaining equipment on board the vehicle.

D. Emergency Ambulance Services - Emergency ambulance services are as described in 9 A.A.C. 22, Article 211.

E. Emergency Ambulance Transportation - Ground or air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the DDD member's condition.

F. Emergency Medical Care Technician (EMCT) - As defined in A.A.C. R9-25-101(18).

G. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

H. Emergency Medical Services - Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

Policy

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by the Division at a percentage, prescribed by law, of the Ambulance provider's ADHS-approved fees for covered services. These rates are contained in the AHCCCS Capped Fee for Service (FFS) Fee Schedule for Certificate of Necessity Providers and will be used by the Division for reimbursement when no contract exists with the provider.

For Ambulance providers, whose fees are not established by ADHS, and no contract exists with the provider, the AHCCCS Capped FFS Fee Schedule is for Ground Transportation will be used by the Division.

Emergency Ground Ambulance Claims are Subject to Medical Review

Claims are submitted with documentation of medical necessity and a copy of the trip report, with the following information:

A. Medical condition, signs, symptoms, procedures, and treatment.

B. Transportation origin, destination, and mileage (statute miles).

C. Supplies.

D. Necessity of attendant, if applicable.

E. Name and DHS numbers of the attendants providing care along with the signature of the trip report author.

Claims submitted without such documentation are subject to denial. The Division will process the claims within the timeframes established in 9 A.A.C. 22, Article 7. *Emergency* transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

Criteria and Reimbursement Processes for Advanced Life Support (ALS) and Basic Life Support

A. Advanced Life Support (ALS) level

1. In order for Ambulance services to be reimbursable at the ALS level, all of the following criteria shall be satisfied**:**

   a. The Ambulance shall be ALS licensed and certified in accordance with A.R.S. §36**-**2202, A.R.S. §36**-**2204, and A.R.S. §36**-**2212,

   b. Emergency Medical Care Technician (EMCT) are present and EMCT services/procedures are medically necessary, based upon the member's symptoms and medical condition at the time of the transport, and

   c. EMCT services/procedures and authorized treatment activities were provided.

B. Basic Life Support (BLS) level

1. In order for Ambulance services to be reimbursable at the BLS level, the following requirements will be met:

   a. The Ambulance must be BLS licensed and certified in accordance with A.R.S. §36**-**2212 and A.A.C. R9-25-201.

   b. EMCT are present

   c. EMCT services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport.

   d. EMCT services/procedures and authorized treatment activities were provided.

Claims submitted without such documentation are subject to denial. The Division processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

Non-Emergent Ground Ambulance Transportation Payment Provisions

A. Non-emergent Ambulance transportation is subject to review for medical necessity by the Division. Medical necessity criteria is based upon the medical condition of the member. Non- emergent transportation by Ambulance is appropriate if:

1. Documentation supports that other methods of transportation are

contraindicated.

2. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an Ambulance.

Non-emergent transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the Division's discretion, non-emergent Ambulance transport may not require prior authorization or notification. This may include after-hours calls. An example is an Ambulance company which receives a call from the emergency room to transport a nursing facility member back to the facility and the Division cannot be reached.

All hospital-to-hospital transfers are paid at the BLS level unless the transfer meets ALS criteria. This includes transportation between general and specialty hospitals.

C. Transportation reimbursement is adjusted to the level of the appropriate alternative transportation when circumstances do not necessitate an Ambulance transport, or the services rendered at the time of transport are deemed not medically necessary. Ambulance providers that have fees established by ADHS are reimbursed in accordance with A.R.S. § 36-2239(H).

Refer to *AMPM Policy 310-BB* for additional requirements for coverage of transportation.

302 PRIOR PERIOD COVERAGE RECONCILIATION: ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 36-2905 and § 36-2944.01; A.A.C. R9-22-101; Patient Protection and Affordable Care Act, Section 9010; ACOM 412

Due to the uncertainty regarding actual utilization and medical cost experience during the Prior Period Coverage (PPC) period, the Division intends to limit the financial risk to its Administrative Services Subcontractors (ADSS). The PPC Reconciliation applies to dates of service effective in Contract Year Ending (CYE) 19 and Forward, and is based upon prior period expenses and prior period net capitation as described in this policy. The Division will recoup/reimburse a percentage of the AdSS's profit or loss for all risk groups as described below. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis, which is October 1 to September 30.

Definitions

A. Access to Professional Service Initiative (APSI) - Effective October 1, 2018, the Division seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to members and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS's rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the definition outlined in ACOM Policy 325.

B. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) built into the rates multiplied by the actual PPC member months for the contract year being reconciled.

C. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

D. Prior Period Coverage (PPC) - The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility until the date the member is enrolled with an AdSS. Refer to A.A.C. R9-22-101. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for the Division via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service (FFS) and the member will be enrolled with the Contractor only on a prospective basis. The time period for prior period coverage does not include the time period for prior quarter coverage.

E. PPC Capitation - Capitation payment for the period of time from the first day of the

month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.

F. PPC Medical Expense - Total expenses covered under the contract for services provided during the PPC time period, which are reported through **fully adjudicated encounters**. This will exclude APSI expenses.

G. PPC Net Capitation - PPC capitation less the administrative component, the health insurer fee capitation adjustment, APSI capitation and the premium tax component.

H. PPC Reconciliation Risk Groups - Populations subject to this reconciliation include all PPC risk groups except State Only Transplants and Adult Group above 106% FPL (Adults > 106%) (formerly known as Newly Eligible Adults or NEAD) (Acute Care Contractors Only).

I. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 and §36-2944.01 for all payments made to AdSSs for the Contract Year.

Policy

A. General

1. The reconciliation must relate solely to fully adjudicated PPC medical expense for all PPC reconciliation risk groups. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to AHCCCS cost settlement will not be included in the reconciliation, the non-enhanced portion of the payment will be included in the reconciliation. The enhanced portion of a payment for APSI that is subject to a unique reconciliation as outlined in ACOM Policy 325 will also be excluded from this reconciliation.

2. The reconciliation will limit the AdSS's profits and losses to 2% of the AdSS's PPC net capitation for all PPC reconciliation risk groups combined (See Attachment A for calculation). Any losses in excess of 2% will be reimbursed to the AdSS, and likewise, profits in excess of 4% will be recouped. The full PPC period is eligible for this reconciliation.

B. Division Responsibilities

1. No less than six months after the contract year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows:

   PPC Net Capitation

   Less: PPC Medical Expense

   Equals: Profit/Loss to be reconciled adjusted for PCP Parity

   The Division may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation.

PPC capitation and medical expense to be included in the reconciliation are based on the **date of service** for the contract year being reconciled.

2. The Division will compare fully adjudicated encounter information to financial statements and other AdSS submitted files for reasonableness.

3. The Division will provide the AdSS with the data used for the initial reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

4. A second and final reconciliation will be performed no less than 12 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide the AdSS with the data used for the final reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

5. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

C. AdSS Responsibilities

1. The AdSS must submit encounters for PPC medical expense and those encounters must reach a fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the medical expenses used in the reconciliation.

2. The AdSS must maintain financial statements that separately identify all PPC transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide.

3. The AdSS must monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis.

4. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments by the initial reconciliation due date. It is also the responsibility of the AdSS to correct (including adjudication of corrected encounters) any identified encounter data issues no later than 12 months after the end of the contract year being reconciled. Reconciliation data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

5. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file).

6. If the AdSS performs recoupments/refunds/recoveries on PPC claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due to the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.

305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155

The Division contracts with Administrative Services Subcontractors (AdSS) and delegate's responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual (same policy number and name as stated above) for the Division policy governing AdSS responsibilities regarding this topic.

314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019

This policy describes the method used to auto-assign members to an Administrative Services Subcontractor (AdSS) and the assignment of available models.

A. Prior to auto-assignment to an AdSS, assignment to a model must be completed.

1. Regarding Annual Enrollment Choice, members who are newly eligible for the Division and ALTCS, and members already enrolled in a plan, may select an available model prior to the start of a new contract.

2. If the member does not select an available model, the Division will assign to Model A.

B. Upon award of a new contract, the Division will auto-assign members as follows:

1. Prior to the start of the contract (choice period), the Division gives current members a choice to select from the newly awarded AdSS contractors.

2. If a member does not select an AdSS during the choice period and the member's current AdSS is awarded a contract, the Division assigns the member to the same AdSS.

3. If a member does not select an AdSS during the choice period and the member's current AdSS is NOT awarded a contract, the Division reassigns the member to one of the newly contracted AdSS.

4. Auto-assignment to a newly contracted AdSS will continue until the number of members assigned to the newly contracted AdSS reaches 50% of the number of members assigned to the AdSS that continued to contract.

5. If all AdSS are new, the Division gives the members a choice to select an AdSS prior to the start of the contract.

C. Ongoing, the Division will auto assign to the available AdSS in a revolving sequence. The Division may change the auto assignment process at any time during the term of the contract in response to AdSS-specific issues (e.g., imposition of an enrollment cap), when in the best interest of the ALTCS Program and/or the state, or to recognize and reward AdSS performance across a variety of factors of importance to the Division.

317 CHANGE IN ORGANIZATIONAL STRUCTURE

REVISION DATE: 10/1/2018

EFFECTIVE DATE: May 13, 2016

REFERENCES: ACOM Policy 438, ACOM 439, ACOM 103; AHCCCS Contract Attachment F3, Contractor Chart of Deliverables, AHCCCS Contract Section D, Corporate Compliance; 42 CFR 106, 42 CFR Subpart B

Purpose

This policy identifies the requirements for submitting changes in the Division's organizational structure resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature or resulting from a planned change in a Management Service Agreement (MSA) Subcontractor. This policy also identifies the Division's role in monitoring and evaluating changes in organizational structure, as defined below, for a Management Service Agreement subcontractor.

Definitions

A. Acquisition – an acquiring, by one company, of all of a target company's assets, capital, or stock.

B. Administrative Services Subcontract - agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:

1. Claims processing, including pharmacy claims
2. Credentialing, including those requirements for only primary source verification
3. Management Service Agreements (MSAs)
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

C. Articles of Incorporation - basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

D. Change In Organizational Structure - any of the following:

1. Acquisition
2. Change in Articles of Incorporation
3. Change in ownership
4. Change of MSA subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet Division contractual requirements)

5. Joint venture

6. Merger

7. Reorganization

8. State agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature

9. Other applicable changes that may cause a change in any of the following:

   a. Employer Identification Number/Tax Identification Number (EIN/TIN)

   b. Critical member information, including the website, member or provider handbook and member ID card

   c. Legal entity name.

E. Change in Ownership - any change in the possession of equity in the capital, stock, profits, or voting rights, with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non- stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

F. Joint Venture - business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants' other business.

G. Management Service Agreement (MSA) - type of subcontract with an entity in which the entity's management delegates all or substantially all management and administrative services necessary.

H. Merger - Two companies join together to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

I. Performance Bond - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

J. Reorganization - An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.

Change in Organizational Structure

A change in organizational structure includes any of the following:

A. Acquisition

B. Change in Articles of Incorporation

C. Change in Ownership

D. Change of MSA Subcontractor

E. Joint Venture

F. Merger

G. Reorganization

H. Other applicable changes that may cause:

1. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

2. Changes in critical member information, including the website, member or provider handbook, and member ID card, or

3. A change in legal entity name.

In addition, a change in organizational structure may require a contract amendment to the Division's contract with AHCCCS. If the Division does not obtain prior approval, or AHCCCS determines that a change in the Division's organizational structure is not in the best interest of the state, AHCCCS may terminate the contract. Similarly, a change in organizational structure may require a contract amendment to the AdSS contract with the Division. If the AdSS does not obtain prior approval, or the Division determines that a change in the AdSS organizational structure is not in the best interest of the state, the Divisiion may terminate the contract. The Division may offer open enrollment to the members assigned to the AdSS should a change in organizational structure occur. The Division will not permit one organization to own or manage more than one contract within the same line of business in the same Geographic Service Area (GSA).

Transition Plan

The Division submits a summary of all changes in organizational structure and a transition plan to AHCCCS 180 days prior to the effective date of the change.

Items in the transition plan, for which information is not yet available for submission, or is still considered draft, must be noted and submitted, or resubmitted, to AHCCCS no later than 90 days prior to the effective date.

As part of the transition plan, the Division will complete an assessment of the following:

A. Any potential interruption of services to members including steps to ensure there are no interruptions

B. The ability to maintain and support the contract requirements

C. Major functions of the Division, as well as Medicaid programs, are not adversely affected

D. The integrity of a fair, competitive procurement process for MSA Subcontractors.

Notification to AHCCCS

When notifying AHCCCS, the considerations listed above, and the following information is included in the summary:

A. Any material change to operations as specified in ACOM Policy 439 and AHCCCS Contract, Section D

B. The state or federal legislation, rule, or action that necessitates a change in Organizational Structure

C. A description of the following:

1. Any changes to the management and staffing of the organization currently overseeing services provided under the contract

2. Any changes to existing Management Services Subcontracts

3. Any changes to the administration of critical components of the organizations, information systems, prior authorization, claims processing, or grievances

4. The plan for communicating the change to members, including a draft notification to be distributed to affected members and providers

5. The planned changes to critical member information, including the website, member and provider handbook, and member ID card

6. Any anticipated changes to the network

7. Any changes in federal or state funding that directly impact the Medicaid line of business.

D. Upon AHCCCS approval of the transition plan, any additional information requested by AHCCCS will be submitted within 120 days of the change, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

The Division submits the following no later than 45 days prior to the effective date of the change in organizational structure and commencement of operations under the new structure, as specified in Contract, Attachment F3, Contractor Chart of Deliverables:

A. Information regarding the Disclosure of Ownership and Control

B. Disclosure of Information on Persons Convicted of a Crime in accordance with 42CFR 455, Subpart B, 42 CFR 455.436, State medicated Director Letters 08-003 and 09-001

C. AHCCCS Contract Section D, Corporate Compliance, and AHCCCS ACOM Policy 103

For a change of MSA Subcontractor, the Division follows the process for the review and approval of the new MSA Subcontractor as outlined in AHCCCS ACOM Policy 438.

Changes in Organizational Structure for an MSA Subcontractor

MSA Subcontractors that also have a contract with AHCCCS must notify the Division at the same time notification is given to AHCCCS. As appropriate, the Division must collaborate with AHCCCS in monitoring and evaluating the transition plan.

The Division evaluates and monitors the transition plan for MSA Subcontractors that do not have a contract with AHCCCS.

320 – HEALTH INSURER PROVIDER FEE

EFFECTIVE DATE: April 29, 2020

REFERENCES: A.R.S. § 36-2905, Section 9010 of the Patient Protection and Affordable Care Act; IRS Form 8963; ACOM Policy 320 Attachment A and Attachment B; Section F3, Contractor Chart of Deliverables

The purpose of this Policy is to define what the Division will submit to AHCCCS and the process by which AHCCCS will provide funding to the Division for the Health Insurance Provider Fee.

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility excluding Indian Health Services, for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual (Chapter 320, Health Insurer Fee) for the Division policy governing AdSS responsibilities regarding this topic.

321 PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: 10/01/2019

REFERENCES: AHCCCS Contract #YH6-0014 Section D, Program Requirements, E-Prescribing. ACOM 321 Payment Reform- E-Prescribing.

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility excluding Indian Health Services, for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Policy 321 Payment Reform – E-Prescribing for the Division policy governing AdSS responsibilities regarding this topic.

404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

REVISION DATE: 1/10/2024, 10/26/2022

REVIEW DATE: 8/4/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10;42 CFR 438.10(c)(4)(ii); 42 CFR 438.310(d)(3);42 CFR 438.10(d)(4); 42 CFR 438.10(f)(1); 42 CFR 457.1207; A.R.S. § 46-297; A.A.C R9-22-504; ACOM 404; ACOM 404, Attachment A , Attachment B , Attachment C ; ACOM 406, Attachment B,

PURPOSE

This policy establishes requirements for the Division of Developmental Disabilities' (Division) Member information and the approval process for Member Information Materials developed or used by the Division. This policy pertains to oral and written communication disseminated to the Division's enrolled Members, and to the content of the Division's website.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" or "AdSS" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims;

b. Pharmacy Benefit Manager (PMB);

c. Dental Benefit Manager;

d. Credentialing, including those for only primary source verification;

e. Medicaid Accountable Care Organization (ACO);

f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner; and

g. CHP and DDD Subcontracted Health Plan.

h. A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Dual Eligible Special Needs Plan" or "D-SNP" means a type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII)

program covered health benefits and full Medicaid (Title XIX) program covered health benefits.

3. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. "File and Use" means a process whereby the AdSS submits qualifying Member Information Materials to the Division prior to use and can proceed with distributing the materials without any expressed approval from the Division.
5. "Human Immunodeficiency Virus" or "HIV" means a Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease. HIV is also commonly transmitted through direct contact with certain bodily fluids (e.g., sharing syringes for intravenous substance use) such as blood, semen, rectal fluids and vaginal fluids, and breast milk.
6. "Incentive Items" for the purpose of this policy means items that are used to encourage behavior changes in enrolled Members or health promotion incentives to motivate Members to adopt a healthy lifestyle and/or obtain health care services.

7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
8. "Member Information Materials" means any materials given to Division membership. This includes, but is not limited to; Member handbooks, Member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a Member's phone.
9. "Prior Authorization" or "PA" means a process by which AHCCCS or the Division, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable Contract provisions. Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.
10. "Value-Added Services" means services, benefits, or positive incentives that promote healthy lifestyles and improve health

outcomes among Members, including items previously defined as Member "Incentive Items."

11. "Vital Materials" means written materials that are critical to obtaining services which include, at a minimum, the following:
    a. Member Handbooks
    b. Provider Directories
    c. Consent Forms
    d. Appeal and Grievance Notices
    e. Denial and Termination Notices

POLICY

A. MEMBER INFORMATION MATERIALS

1. The Division shall comply with the requirements in ACOM 404 for all Member Information Materials, as well as the following related requirements:
    a. Cultural Competency, Language Access Plan and Family/Patient Centered Care (ACOM 405),
    b. Member Handbook and Provider Directory (ACOM 406),
    c. Social Networking activities (ACOM 425),
    d. Member ID Cards (ACOM 433),

e. Change in Contractor Organizational Structure, or change in contractor name (ACOM 317),

f. Material Changes (ACOM 439),

g. Notice of Adverse Benefit Determination and Notice of Extension samples of templates (ACOM 414),

h. The Division Contract, Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters, when indicated; and

i. Maternal Child Health/EPSDT Member outreach information (AMPM Exhibit 400-3).

2. The Division shall attest it is in compliance with Member information requirements by signing and submitting ACOM 404, Attachment C.

3. The Division shall provide all Member Information Materials to Members and potential Members in a manner and format that may be easily understood and is readily accessible by Members and potential Members.

4. The Division shall inform Members that Member information is available in paper form, without charge and upon request, and shall provide it upon request within five business days.
5. The Division shall use state developed Member notices as indicated in contract and policy.
6. The Division shall make a good faith effort to give written notice to Members who received primary care from, or who are seen on a regular basis by, a provider who is terminated from the network. Written notice shall be provided to the Member:
    a. Within the latter 30 calendar days prior to the effective date of the provider termination, or
    b. 15 calendar days after the receipt or issuance of the provider termination notice.
7. The Division shall submit draft Member notifications to AHCCCS that are components of a material change even if previously submitted as a Member Information Material.
8. The Division shall ensure website checklist items are passed on to its Subcontracted Health Plans and are easily and readily

available for Members on its website, including links to Subcontracted Health Plan Member Information Materials.

B. LANGUAGE, READABILITY, INTERPRETATION AND TRANSLATION REQUIREMENTS

1. The Division shall ensure all Member Information Materials include taglines in the prevalent non-English languages in Arizona and include large print, conspicuously visible font size, explaining the availability of translation or interpretation services with the Division's toll free and TTY/TDY telephone numbers for customer service, which shall be available during normal business hours.
2. The Division shall provide Members with the Division's toll free and TTY/TDY nurse triage line telephone number which shall be available 24hr/7days a week.
3. The Division shall make Vital Materials available in the prevalent non-English language spoken for each Limited English Proficiency (LEP) population.
4. The Division shall not substitute Oral Interpretation services for written translation of Vital Materials.

5. The Division shall ensure translation of Vital Materials is accurate and culturally appropriate.
6. The Division shall translate all written materials for Members into Spanish regardless of whether or not the materials are vital.
7. The Division shall ensure that all information prepared for distribution is written in an easily understood language and format for readability through the following measures:
    a. Maintain the information at a sixth grade reading level as measured on the Flesch-Kincaid scale.
    b. Use a font size no smaller than 12 point.
    c. Member Information Materials are made available in alternative formats and in an appropriate manner that takes into consideration special needs including:
        i. Visual limitation,
        ii. Other disabilities, or
        iii. Limited reading proficiency.
    d. Large print materials are made available using a conspicuously visible font size.

8. The Division shall makes oral interpretation services, as well as written translation of documents from English into the Member's preferred language, available to Members at no cost. Services for all non-English languages and the use of auxiliary aids such as TTY/TDY and American Sign Language are available.

C. VALUE-ADDED SERVICES

1. The Division shall offer Value-Added Services to Members which promote healthy lifestyles and improve health outcomes when opportunities arise.
2. The Division shall not offer Value-Added Services to Members to influence continued enrollment with the Division.
3. The Division shall not offer Value-Added Services such as Incentive Items that are exchangeable for items prohibited.
4. The Division shall offer Value-Added Services in a culturally sensitive, unbiased, and equitable manner.
5. The Division shall not receive compensation for Value-Added Services and shall not report the cost of Value-Added Services as allowable medical or administrative costs.

D. MATERIALS NOT REQUIRING SUBMISSION TO AHCCCS

1. Division staff shall not submit the following materials to AHCCCS for approval:
    a. Customized letters for individual Members.
    b. Information sent by the Division to Members enrolled in a Medicare Dual Special Needs Plan (D-SNP) that clearly and exclusively relates to their Medicare benefits and services.
    c. Health related brochures developed by a nationally recognized organization included in ACOM 404 Attachment A do not require submission to AHCCCS prior to distribution to Members, unless they reference any of the following, in which case the Division shall not distribute them at all, although the Division may utilize them to develop their own materials:
        i. Services which are not medically necessary,
        ii. Services which are not AHCCCS covered benefits; or
        iii. Services which do not align with Division policy.
2. The Division shall submit a request to add additional names of other organizations to ACOM 404 Attachment A upon identifying an organization missing from the list.

3. The Division shall refer to ACOM 404 for updates when considering using information from organizations listed in Attachment A.
4. The Division shall review the content of materials developed by the organizations listed in Attachment A to ensure that:
    a. The services are covered by the Division.
    b. The information is accurate.
    c. The information is culturally sensitive.
5. The Division shall supplement or replace educational brochures customized for Medicaid Members developed by outside entities to educate Members.

E. MEMBER NEWSLETTER CONTENT AND REQUIREMENTS

1. The Division shall develop and distribute, at a minimum, two Member newsletters during each contract year.
2. The Division shall submit newsletters to AHCCCS in the form of an initial mock-up version of what the Member will be receiving, in addition to the individual articles referencing readability levels.
3. The Division shall not use the File and Use review process for the Member newsletter.

4. The Division shall include at a minimum, the following in the Member newsletter at least annually except as otherwise indicated:
    a. Educational information on chronic illnesses and ways to self-manage care;
    b. Reminders of flu shots and other preventative measures at appropriate times;
    c. Medicare Part D issues;
    d. Cultural Competency, other than translation services;
    e. Contractor specific issues in each newsletter;
    f. Tobacco cessation information;
    g. HIV/AIDS testing for pregnant women;
    h. Suicide Prevention information;
    i. Opioid/Substance Use information;
    j. Information on Peer and Family Supports;
    k. Contractor contact information and 988 Crisis Hotline information in each newsletter;

l. Educational information on how the Division is addressing health equity and resources to assist with Social Determinants of Health;

m. Where to find resources for support with health-related social needs, which may include a link to the Division's Community Resource Guide;

n. Information on the Division's integration efforts to improve overall Member health outcomes~~,~~ as applicable;

o. Information on Non-Title XIX/XXI Services as appropriate; and

p. Other information required by the Division or AHCCCS.

F. WEBSITE CONTENT

1. The Division shall ensure the Division website contains all of the information required in ACOM 404 - Attachment B.
2. The Division shall provide written notice to Members of the availability for the newsletter if newsletters are provided electronically.
3. The Division shall submit ACOM 404 Attachment B to AHCCCS annually.

4. The Division shall ensure:
    a. All information is located on the Division's website in a manner that Members can easily find and navigate from the Division's home page.
    b. Information is in a format that can be retained and printed by the Member.
    c. Websites are specific to the Division's Medicaid program and shall not include links or references to private insurance.
5. The Division shall include links and references to the Division's Medicare programs and services that exclusively promote coordination of care for Members enrolled in both Medicare and Medicaid on the Division's website.
6. The Division shall refer to ACOM 404 for the approval process for additional information added to the Division's website that is directly related to Members or potential Members, refer to requirements outlined in this Policy.

G. SUBMISSION, REQUIREMENTS AND RESTRICTIONS FOR ALL OTHER MATERIALS

1. The Division shall submit to AHCCCS all other Member Information Materials intended for dissemination to Division Members 15 calendar days before they are to be released, for File and Use review.
2. The Division shall request an expedited review if a 15-day notice is not possible.
3. Division staff requesting an expedited review shall ensure the request is expedited.
4. Division staff requesting an expedited review shall ensure the reason for the shortened time frame is indicated in the request.
5. Division staff shall consider factors and materials which may require additional time to be reviewed include Member Information Materials which are:
    a. A component of new initiatives;
    b. Special projects;
    c. Consisted of bulk submission.
6. The Division shall submit Member Information Materials to AHCCCS for approval, prior to using them for marketing purposes as specified in ACOM 101.

7. The Division may disseminate the Member information as indicated in their request upon the expiration of the 15-day time period~~,~~ unless AHCCCS notifies the Division otherwise.
8. Division staff submitting Member Information Materials to AHCCCS for approval shall consider Member materials submitted outside of standard business hours will be considered received the following business day.
9. Division staff submitting Member Information Materials to AHCCCS for approval shall consider State holidays that fall on business days are not counted as part of the 15-day review period.
10. The Division shall not consider Member Information Materials developed for services under contract with AHCCCS to be proprietary to the Division.
11. The Division shall submit the following information to AHCCCS prior to releasing Member Information Materials:
    a. A cover letter containing
        i. a description of the purpose,

ii. the process the Division will use to disseminate the material, and

iii. the reading level of the material level as measured on the Flesch-Kincaid scale.

b. A copy, transcript, screenshot, or other documentation of the material as intended for distribution to its Members or potential Members. Translations of the materials into other languages as required by this policy, are not required to be submitted.

12. The Division shall inform all Members of any changes considered to be significant by AHCCCS, 30 calendar days prior to the implementation date of the change. These changes include:
    a. AHCCCS covered drug list;
    b. Cost Sharing;
    c. Prior Authorization;
    d. Service Delivery;
    e. Covered Services; and
    f. Other changes as required by AHCCCS.
13. The Division shall ensure:

a. All materials are labeled with the Division's name or logo, including:
    i. Member material located on the Division's website;
    ii. Email messages;
    iii. Voice or text-recorded phone messages delivered to the Member's phone; and
    iv. Other information as requested by AHCCCS.
b. Information contained within the material is:
    i. Accurate;
    ii. Updated regularly; and
    iii. Appropriately based on changes in benefits, Contract, policy, or other relevant updates.
c. Updated Member information is re-submitted for approval, including:
    i. The date the material was previously approved;
    ii. The reason for the update; and
    iii. Clearly identify all content revisions.
d. A log is kept for all Member Information Material distributed each year, the log shall identify:

i. The date the material was originally submitted to AHCCCS; and

ii. Resubmission dates.

e. The log of Member Information Materials is made available to AHCCCS upon request.

f. Member Information Materials:

i. Do not directly or indirectly refer to the offering of private insurance,

ii. Do not include inaccurate, misleading, confusing or negative information about AHCCCS or the Division, or any information that might defraud Members.

g. Member Information Materials do not use the word "free" in reference to covered services.

h. Member Information Materials directly relate to the administration of the Medicaid program, or relate to health and welfare of the Member.

i. Member Information Materials do not have political implications; and,

j. Retention materials do not refer to competing plans.

405 CULTURAL COMPETENCY, LANGUAGE ACCESS PLAN, AND FAMILY/ MEMBER CENTERED CARE

EFFECTIVE DATE: July 19, 2023

REFERENCES: 42 CFR 457.1230(a), 42 CFR 457.1201(d), 42 CFR 438.206(c)(2), 42 CFR 438.3(d)(4), and 45 CFR Part 92; ACOM 405.

PURPOSE

The purpose of this Policy is to set forth Division requirements for providing health care services in a culturally and linguistically competent manner.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor (AdSS)" means an agreement that delegates any of the requirements of the Contract with Arizona Health Care Cost Containment System (AHCCCS), including, but not limited to the following:
    a. Claims processing, including pharmacy claims,
    b. Pharmacy Benefit Manager (PMB),
    c. Dental Benefit Manager,
    d. Credentialing, including those for only primary source verification,
    e. Management Service Agreements,

f. Medicaid Accountable Care Organization (ACO),

g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner; and

h. DDD Subcontracted Health Plan. A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Cultural Competency" means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables that system, agency, or those professionals to work effectively in cross-cultural situations.

a. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

b. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

3. "Family-Centered" means care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate the member directs the involvement of the family to ensure person-centered care.

4. "Interpretation" for the purpose of this policy means the conversion of oral communication from one language into another while maintaining the original intent.

5. "Language Assistance Service" means services including, but not limited to:

a. Oral language assistance, including Interpretation in non-English languages provided in-person or remotely by a Qualified Interpreter for an individual with Limited English Proficiency, and the use of qualified bilingual or

multilingual staff to com]municate directly with individuals with Limited English Proficiency,

b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages other than English; and

c. Taglines.

6. "Limited English Proficiency (LEP)" means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be Limited English Proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

7. "Linguistic Need" means, for the purposes of this policy, the necessity of providing services in the member's primary or preferred language, including sign language, and the provision of interpretive and Translation services.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone,a video remote interpreting (VRI) service, or an on-site appearance:
   a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,
   b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness; and
   c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.
10. "Qualified Translator" means for the purpose of this policy, a translator who:
   a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

b. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

c. Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

11. "Translation" means, for the purpose of this policy, the conversion of written communication, while taking into consideration the cultural context, content and spirit of the message, while maintaining the original intent.

12. "Vital Materials" means information, provided to the member, which assists the member to receive covered services through the Arizona Long Term Care System (ALTCS) program. These materials include but are not limited to:

a. Member handbooks,

b. Notices of Adverse Benefit Determinations,

c. Notices of Appeal Resolution,

d. Consent forms,

e. Member notices,

f. Communications requiring a response from the member,

g. Grievance, appeal, and request for state fair hearing information, or

h. Written notices informing members of their right to Interpretation and Translation services.

POLICY

A. CULTURAL COMPETENCY PLAN (CCP)

1. The Division shall develop and maintain a comprehensive Cultural Competency program that:

   a. Is inclusive of those with LEP and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity.

   b. Includes measurable and sustainable goals,

   c. Is available in a written format,

d. Describes how care and services will be delivered in a culturally competent manner, and shall include all information as specified in ACOM 405 Attachment A,

2. The Division shall identify a staff member responsible for implementation and oversight of all requirements for the Cultural Competency program and plan.

3. The Division shall require its workforce to adhere to all Cultural Competency requirements as specified in this Policy.

4. The Division's CCP shall also include:

   a. A description of the method(s) used for evaluating the cultural diversity of its membership to assess needs and priorities to provide culturally competent care to its membership,

   b. An evaluation of its network, outreach services, and other programs to improve accessibility and quality of care for its membership,

   c. A description of the method(s) used for evaluating health equity and addressing health disparities within the Division's service delivery,

d. A description of the provision and coordination needed for linguistic and disability related services; and

e. A description of education and training that includes:

   i. Methods used to train its workforce to ensure that services are provided in a culturally competent manner to members of all cultures,

   ii. Training customized to fit the needs of the workforce based on the nature of the contacts with providers and members,

   iii. Cultural Competency training for the entirety of the workforce during new employee orientation and annually thereafter,

   iv. Methods used to train members of the workforce with direct member contact,

   v. Education designed to make members of the workforce and AdSSs aware of the importance of providing services in a culturally competent manner and understanding of health literacy,

vi. The Division shall also make additional efforts to train or assist its workforce and Division AdSSs with how to provide culturally competent services; and

vii. The Division shall track workforce participation in Cultural Competency trainings.

B. TRANSLATION AND INTERPRETATION SERVICES

1. The Division shall ensure access to oral Interpretation, Translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request, and at no cost to the member.
2. The Division shall provide Translation and Interpretation services that are accurate, timely, and that protect the privacy and independence of the individual with LEP.
3. The Division shall ensure Translation services are provided by a Qualified Translator, and Interpretation services are provided by a Qualified Interpreter.
    a. The Division shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to

use an adult accompanying the member with LEP for Interpretation in the following situations:

i. When danger is imminent or there is a threat to the welfare or safety of the member, and no Qualified Interpreter is immediately available; or

ii. After receiving the Division's offer and recommendation to use a Qualified Interpreter, the member with LEP requests the accompanying adult to interpret or facilitate the communication, the accompanying adult agrees to provide the communication assistance, and reliance on the accompanying adult for assistance is reasonable under the circumstances.

b. Division staff shall advocate for use of Qualified Interpretation services when an adult accompanying the member is providing communication assistance and:

i. There is a concern that the Interpretation is not accurate; or

ii. The content of the conversation is potentially inappropriate to be shared or provided with the accompanying adult.

c. The Division shall only permit reliance upon minor children for Interpretation assistance when:

i. In an urgent emergency situation when danger is imminent, or there is a threat to the welfare or safety of the member; and

ii. There is no Qualified Interpreter immediately available.

d. The Division staff shall follow up with a Qualified Interpreter to verify information after the emergency is over, in the event that a minor child has been relied upon to provide Interpretation assistance.

e. The Division shall not rely on a minor child for Translation of documents.

4. The Division shall ensure Translations and Interpretations are provided in the following manner:

a. All written materials for members shall be translated into Spanish regardless of whether or not the materials are vital.

i. Vital Materials shall be made available in the prevalent non-English language spoken for each LEP population in the Division's service area.

ii. Oral Interpretation services shall not substitute for written Translation of Vital Materials.

b. Oral Interpretation services available at no cost to the member.

i. This applies to sign language and all non-English languages, not just those identified as prevalent.

ii. Information shall be made available on which providers speak languages other than English.

5. The Division shall provide member information materials in compliance with ACOM Policy 404.

6. The Division shall:

a. Utilize licensed interpreters for the Deaf and the Hard of Hearing, and

b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the member upon request. Auxiliary aids include:

i. Computer aided transcriptions,

ii. Written materials,

iii. Assistive listening devices or systems,

iv. Closed and open captioning; and

v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

C. CULTURAL COMPETENCY PLAN ASSESSMENT REPORTING

1. The Division shall assess its CCP for effectiveness. The assessment shall include modifications as appropriate based on evaluation of the CCP. The CCP Assessment shall consider the following:

a. Linguistic Need,

b. Comparative member satisfaction surveys,

c. Outcomes for certain cultural groups,

d. Translation and Interpretation services and utilization,

e. Member complaints and grievances,

f. Provider feedback; and

g. Division employee surveys.

2. The Division shall track and trend identified issues, and actions taken to resolve those identified issue(s).

3. The CCP shall also address how the Division communicates its progress in implementing and sustaining the CCP goals to all stakeholders, members, and the general public.

4. The CCP Assessment shall be submitted with ACOM 405 Attachment A to the DDD Compliance department.

D. LANGUAGE ACCESS PLAN

1. The Division shall submit a Language Access Plan with ACOM 405 Attachment A annually, that indicates how the needs of members with LEP are met.

2. The Language Access Plan shall address each of the following elements:

a. Assessment: Needs and Capacity

Processes to regularly identify and assess the language assistance needs of its members, as well as the processes

to assess the Division's capacity to meet these needs according to the elements of this plan.

b. Language Assistance Service

The Division shall provide the established point of contact for members who need Language Assistance Services. The Division shall include the process used to ensure that the interpreters used are qualified to provide the service and understand interpreter ethics and member confidentiality needs.

c. Written Translations

Processes to identify, translate, and make accessible in various formats vital materials in accordance with assessments of need and capacity conducted as specified in assessment.

d. Policies and Procedures

Written policies and procedures ensuring members with LEP have meaningful access to programs and activities.

e. Notification of the Availability of Language Assistance at No Cost

Processes to ensure meaningful access to the Division's programs including notifying current and potential members with LEP about the availability of language assistance at no cost. Notification methods may include multilingual taglines in member materials, as well as statements on forms including electronic forms such as agency websites. The results as specified in the Needs and Capacity Assessment above should be used to determine the languages in which the notifications should be translated.

f. Workforce Training

Description of employee training to ensure management and staff understand and can implement the policies and procedures of the Language Access Plan.

g. Assessment: Access and Quality

Processes to regularly assess the accessibility and quality of language assistance activities for members with LEP, maintain an accurate record of Language Assistance

Services, and implement or improve LEP outreach programs and activities in accordance with customer need.

h. Stakeholder Consultation

Process for engaging stakeholder communities to identify language assistance needs of members with LEP, implement appropriate language access strategies to ensure members with LEP have meaningful access in accordance with assessments of member need and evaluate progress on an ongoing basis.

i. AdSS Assurance and Compliance

Processes for ensuring AdSSs understand and comply with their obligations under civil rights statutes and regulations enforced by AHCCCS related to language access.

E. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

The Division shall provide Family-Centered care in all aspects of the service delivery system for members with special health care needs. The additional responsibilities of the Division for support of Family-Centered care include but are not limited to:

1. Recognizing the family as the primary source of support for the member's health care decision-making process. Service systems and personnel shall be made available to support the family's role as decision makers;
2. Facilitating collaboration among members, families, health care providers, and policymakers at all levels for the:
    a. Care of the member,
    b. Development, implementation, evaluation of programs; and
    c. Policy development.
3. Promoting a complete exchange of unbiased information between members, families, and health care professionals in a supportive manner at all times;
4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, economic diversity, gender, gender identity, and individuality within and across all families;
5. Implementing practices and policies that support the needs of members and families, including medical, developmental,

educational, emotional, cultural, environmental, and financial needs;

6. Participating in Family Centered Cultural Competency Trainings,
7. Facilitating family-to-family support and networking,
8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family;
9. Acknowledging that families are essential to the members' health and well-being and are crucial allies for quality within the service delivery system; and
10. Appreciating and recognizing the unique nature of each member and their family.

F. SUPPLEMENTAL INFORMATION

The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids, and the complete rules and regulations regarding the profession of interpreters in the State of Arizona.

406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

REVISION DATE: 11/8/2023, 12/21/2022

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 457.1207; 42 CFR 438.10, 42 CFR 438.102; ACOM 404-Attachment C, ACOM 406-Attachment A; ACOM 406-Attachment B

PURPOSE

This policy sets forth guidelines for development, review, and distribution of Member Handbooks and Provider Directories.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Multi-Specialty Interdisciplinary Clinic (MSIC)" - means a facility where specialists from more than one specialty meet with Members and their families in order to provide interdisciplinary services to treat Members.
4. "Planning Document'' means a written plan developed through

an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
6. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall provide annually a Member Handbook and Provider Directory to the Responsible Person.
2. The Division shall ensure the Member Handbook contains all information required, as identified in ACOM 406 Attachment A, including definitions as required by Centers for Medicare and

Medicaid Services (CMS) specified in ACOM 406 Attachment B, Definitions for AHCCCS Members.

3. The Division shall ensure required information is incorporated into the Division's Member Handbook in the order identified on the Checklist.
4. The Division shall submit the Member Handbook as described in the section "Member Handbook Review Process" of this policy.
5. The Division may publish information modifying or expanding the contents of the Division's Member Handbook, if the Division identifies a need.
6. The Division may distribute modified or expanded content in the form of inserts and supply these inserts with subsequently distributed Member Handbooks, if the Division identifies the need.
7. The Division shall update paper provider directories at least quarterly and electronic provider directories no later than 30 days after the Division receives updated provider information.

8. The Division shall ensure that the electronic versions of the Member Handbook and the Provider Directory meet the following requirements:
    a. The format is readily accessible;
    b. The information is located in a place on the DDD website that is prominent and readily accessible;
    c. In a machine readable format which can be electronically saved-and printed;
    d. The information is consistent with federal content and language requirements;
    e. The information is available in paper form upon request, at no cost, and will be provided within five Business Days of the request; and
    f. The information adheres to the requirements identified in Policy 416 of the Division Operations Policy Manual.
9. The Division shall ensure the Member Handbook and the Provider Directory adhere to language and format requirements as outlined in Division Operations Policy 404.

B. MEMBER HANDBOOK REVIEW PROCESS

1. The Division shall submit to AHCCCS the Division's Member Handbook, along with a track changes version reflecting changes from the previous contract year, annually.
2. The Division shall annually submit a cover letter to include the requirements as identified in Attachment A, as specified in the AHCCCS contract, or, as directed by AHCCCS.
3. The Division shall provide a final copy of the Member Handbook to AHCCCS, after AHCCCS has provided approval of a draft.
4. The Division shall ensure the Member Handbooks and Provider Directories issued by Subcontracted Health Plans (AdSS) align with the requirements of ACOM 406.

C. DISTRIBUTION REQUIREMENTS

1. Provider Directory:
    a. The Division shall provide a Provider Directory to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.
    b. The Division shall provide the Provider Directory in either hard copy or electronic format.

c. The Division shall provide written notification via electronic mail or via postal mailing that outlines where the directory can be found on the Division's website.

i. The Division shall include this notification in the Member Handbook or mail the notice separately.

ii. The Division shall obtain approval for this notice in accordance with ACOM 404.

iii. The Division shall give the Responsible Person the option to obtain a hard copy version of the Provider Directory.

2. Member Handbook:

a. The Division shall provide the Member Handbook to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.

b. The Division shall provide a hard copy of the Member Handbook to each Responsible Person.

c. Division Support Coordinators shall:

i. Provide to and review the Member Handbook with the Responsible Person annually, and

ii. Document this review in the Acknowledgement of Publications section of the member's planning document.

3. The Division may, at its discretion, require AdSSs to provide written notification that the AdSS's Member Handbook and Provider Directory are available on the AdSS' website, upon request via electronic mail, or by postal mailing.
4. The Division shall make copies of the Member Handbook available to known consumer and family advocacy organizations and other human service organizations when requested.
5. The Division may be required to update Member Handbooks throughout the contract year, if the Division identifies a need to address program changes for inclusion, through inserts in the Member Handbook:
   a. The Division shall incorporate these changes in subsequently distributed handbooks through inserts until the handbooks are updated with the new information, and
   b. The Division shall post the content of the insert on the Division website.

6. The Division shall:

    a. Ensure Member Handbook and Provider Directory requirements are delegated to AdSSs.

    b. Review AdSS's Member Handbooks and Provider Directories for approval in accordance with ACOM 406.

D. PROVIDER DIRECTORY CONTENT

1. The Division shall have a user-friendly, searchable, electronic Provider Directory on the Division's website.
2. The Division shall also make available in an electronic and hard copy format a Provider Directory.
3. The Division shall include the following provider information in the Provider Directory:

    a. Provider name as well as any group affiliation,

    b. Provider address, ensuring virtual-only status is indicated for virtual-only providers in place of a physical address;

    c. Provider telephone number,

    d. Web site Uniform Resource Locator (URL), as appropriate,

    e. Specialty as appropriate,

    f. Non-English languages spoken,

g. Whether or not the provider is accepting new patients,

h. Information for the Long Term Services and Supports (LTSS) Providers, as applicable.

i. The provider's cultural and linguistic capabilities, including languages, including American Sign Language offered by the provider or a skilled medical interpreter at the provider's office.

j. The location of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract,

k. A designation identifying network offices that offer reasonable accommodations for Members including but not limited to: physical access, accessible equipment and culturally competent communications and a description of how the Responsible Person can obtain details of the accommodations for specific providers;

l. Innovative service delivery mechanisms such as field clinics and virtual clinics and an Integrated Medical Record

to provide Multi-Specialty, Interdisciplinary Care when needed in other areas of the State;

m. Information on the services, offered through telemedicine and mobile providers, and how to access these services; and

n. Physicians, psychiatrists, laboratory, x-ray, and therapy services available onsite at the MSIC.

407 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: October 1, 2018

REFERENCE: AHCCCS Contractor Operations Manual (ACOM) Policy 407

PURPOSE

The purpose of this policy is to describe the Division's requirements regarding:

1. Monitoring and collection of information about the workforce;
2. Collaborative planning of workforce development initiatives, including the recruitment and employment of members of the Division into healthcare roles; and
3. When needed, the provision of direct assistance to Qualified Vendors and AdSS Health Plans to develop the workforce.

DEFINITIONS

1. "Competency" means a worker's demonstrated ability to intentionally, successfully, and efficiently perform the basic requirements of a job, multiple times, at or near the required standard of performance.

2. "Competency Development" means a systematic approach for ensuring the workers are adequately prepared to perform the basic requirements of their jobs.
3. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
4. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
5. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and or connecting workers to information.
6. "Workforce Development Alliance (WFDA)" means a coalition of the Workforce Development (WFD) Administrators from each contractor that jointly plan and conduct WFD activities for a particular line of business.
7. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources

that the Division implements, including monitoring and addressing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to provider organizations to strengthen their WFD programs.

8. "Workforce Development Plan (WFD-P)" means the blueprint for ensuring the ongoing growth and development of the network's workforce.

POLICY

A. GENERAL

1. The Division shall work with AHCCCS, Qualified Vendors, and Administrative Services Subcontractors (AdSS) to ensure members of the Division receive services from a workforce that is qualified, capable, and sufficiently staffed.
2. The Division shall ensure that providers acquire, develop, and deploy a sufficiently staffed and qualified workforce that capably delivers services to members.
3. The Division shall generate policies that shape worker, workplace, and workforce development practices.

4. The Division shall ensure that provider workforce management and development processes align with AHCCCS workplace and workforce development policies.
5. The Division shall:
    a. Monitor the performance of the network;
    b. Collect information about the workforce;
    c. Develop plans to strengthen the workforce; and
    d. When needed, directly assist providers to develop and maintain a qualified, capable, and sufficiently capacitated workforce.
6. The Division shall ensure that subcontracted provider organizations are deploying a qualified, sufficiently staffed workforce that capably provides services to members of the Division in an interpersonally, clinically, culturally, and technically effective manner.
7. The Division shall offer training and resources to providers to assist professionals and family caregivers with managing stress and burnout as required by the Report of Abuse & Neglect Prevention Task Force.

B. ESTABLISH AND MAINTAIN A WORKFORCE DEVELOPMENT OPERATION

The Division shall:

1. Establish and maintain a Workforce Development Operation (WFDO).
2. The WFDO shall work together with Network Management, Quality Management, and Cultural Competency programs to ensure the provider workforce has the capacity needed to provide services and the diversity and capability required to competently deliver them.
3. Name a Workforce Development Administrator to lead the WFDO who shall:
    a. Manage the AdSS and Qualified Vendors' network specific process of continuous workforce quality development and improvement;
    b. Be a collaborating partner in the statewide WFDA; and
    c. Have a professional background, authorities, and ongoing training and development needed to lead the WFDO as specified in the AHCCCS contract.

4. Equip the WFDO with the organizational personnel and information processing support required to execute the following responsibilities of the WFDO:
    a. Monitor and assess current workforce capacity and capability;
    b. Forecast and plan future or needed workforce capacities and capabilities;
    c. Deliver technical assistance to provider organizations to strengthen their WFD programs;
    d. Monitor, assess, forecast, plan, and provide technical assistance both independently and in coordination with the WFDOs of the other Contractors by:
        i. Independently acting on the workforce needs of the provider network as identified by the network and quality management departments.
        ii. Coordinating with other WFDOs of Contractors to:
            1) Achieve statewide system and industry specific WFD goals;

2) Ensure that WFD processes, such as system-wide orientation and training programs, are uniformly applied; and

3) Prevent the miscommunication of WFD priorities as well as mitigate administrative burden associated with developing the workforces of the statewide provider community.

5. Ensure the provider workforce has access to, and follows, all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, and other agency generated plans.
6. Ensure that providers have access to all the resources necessary to engage designated audiences and satisfy the WFD requirements as specified in AHCCCS policies, guidance documents, manuals, contracts, and other agency generated plans.

C. WORKFORCE DEVELOPMENT PLAN

1. The Division shall produce a Workforce Development Plan (WFD-P) as specified in ACOM 407 Attachment A in collaboration with:
    a. Providers;
    b. Members of the Division and their families; and
    c. Other stakeholders, including but not limited to:
        i. Other Contractors and industry;
        ii. Education groups; and
        iii. Community groups.
2. The Division shall ensure the WFD-P:
    a. Determines areas where, relative to network and quality requirements, specific increases in workforce capacity and/or worker competency and capability are needed;
    b. Determines if the WFD programs of a single provider, or WFD programs of the provider network, for acquiring, developing, and maintaining a sufficiently staffed, diverse, and capable workforce should be enhanced to ensure compliance with the Division's network and quality requirements; and

c. Develops and implements a plan of action designed to increase or improve workforce capacity and/or capability by working collaboratively with providers to develop the workforce and/or enhance their current WFD programs.

3. The Division shall ensure the Network WFD-P includes, but is not limited to, the following components:
   a. Description of the Division's WFDO;
   b. Workforce Profile;
   c. Workforce Capacity Assessment, Developmental Goals, and Work Plan; and
   d. Workforce Capability/Competency Assessment, Development Goals, and Work plan.
4. The Division shall submit the WFD-P to AHCCCS as specified in the Contract.

D. MONITOR WORKFORCE DEVELOPMENT ACTIVITIES

1. The Division shall develop and maintain workforce development policies and a WFD Plan.
2. The Division shall ensure Qualified Vendors and AdSS Health Plans develop and maintain workforce development policies and

a WFD Plan as part of the routine monitoring process, and ensure:

a. The provider workforce has access to, and is in compliance with, all workforce training and/or competency requirements specified in federal and state law, Division policies, guidance documents, manuals, contracts, other agency generated plans.

b. All Division required training content or competency descriptions are incorporated into the appropriate orientation, basic, specialized, or advanced levels of education or training program and evaluated processes, and are made available to provider personnel.

c. There are processes for:

    i. Documenting training;

    ii. Verifying qualifications, skills, and knowledge of personnel; and

    iii. Retaining required training and competency transcripts and records.

d. All initiatives specified in the Network WFD-P are routinely monitored and evaluated.

E. WORKFORCE DATA

1. The Division shall collect and analyze required and ad hoc workforce data that:
   a. Proactively identifies potential challenges and threats to the viability of the workforce,
   b. Conducts analysis of the potential impact of the challenges and threats to access to care for members,
   c. Develops and implements interventions to prevent or mitigate threats to workforce viability, and
   d. Develops indicators to measure and monitor workforce sustainability.
2. The Division shall use the collected data to directly assist the AHCCCS WFD Administrator develop a comprehensive workforce assessment and forecast of WFD priorities.

F. PROVIDER TECHNICAL ASSISTANCE

1. The Division shall determine the need, scope, and the most effective and efficient methods for providing technical assistance to providers.
2. As needed, the Division shall provide technical assistance to providers to develop, implement, and improve programs for workforce recruitment, selection, evaluation, education, training, and retention that may include:
    a. Workforce development planning,
    b. Talent identification and acquisition,
    c. Competency based training and development programs and systems,
    d. Workforce retention and promotion strategies, and
    e. Workplace culture development.

412 CLAIMS RECOUPMENT

REVISION DATE: 7/10/2019
EFFECTIVE DATE: May 20, 2016
INTENDED USER(S): Division Claim staff

REFERENCES: DES/DDD AHCCCS Contract, Section D; ACOM Policy 203, 434; AHCCCS Claims Dashboard Reporting Guide; A.R.S. §§ 36-2901, 35-214; A.A.C. R9- 22-701 et seq., R9-28-701 et seq., The Deficit Reduction Act of 2005 (Public Law 109-171); 42 CFR 438.600 et seq.

This policy identifies the AHCCCS requirements for the Division's claims recoupment and refund activities.

Definitions

A. Day - Calendar day unless otherwise specified.

B. Provider - Any individual or entity that contracts with AHCCCS or the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a Provider delivering services. For the purposes of this policy, a Provider delivering services pursuant to A.R.S. §36-2901.

C. Recoupment - The process the Division takes to recover all or part of a previously paid claim(s). Recoupments include Division initiated/requested repayments, as well as overpayments identified by the Provider where the Division seeks to actively withhold or withdraw funds to correct the overpayment from the Provider.

D. Refunds - An action initiated by a Provider to return an overpayment to the Division. In these instances, the Provider writes a check or transfers money to the Division directly.

Policy

The Division is responsible for reimbursing Providers and coordinating care for services provided to a member pursuant to state and federal regulations, including, but not limited to A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq.

The Division is required to follow AHCCCS Recoupment provisions as outlined in Contract and Policy. For requirements for adjudication and payment of claims and encounters, refer to ACOM Policy 203. The Division's claims processes, as well as its prior authorization, and concurrent and retrospective review processes, minimize the likelihood of the need to recoup paid claims.

An adjustment that is completed within 30 days from the date of the original payment does not require AHCCCS prior approval, but will be tracked and made available to AHCCCS upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

Adjustments completed more than 30 days from the date of the original payment *may* require AHCCCS prior approval, as outlined below.

Individual Recoupments in Excess of $50,000

Prior to initiating any individual Recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Division submits a written request for approval *as specified in Contract* (30-days) or earlier if the information is available, in the format detailed below:

A. A detailed letter of explanation will be submitted with the following:

1. How the need for recoupment was identified.
2. The systemic causes resulting in the need for a recoupment
3. The process that will be utilized to recover the funds
4. Methods to notify the affected Provider(s) prior to recoupment
5. The anticipated timeline for the project
6. The corrective actions that will be implemented to avoid future occurrences.
7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted
8. Other recoupment action(s) specific to this Provider within the contract year.

B. An electronic file containing the following:

- AHCCCS member ID
- Date of service
- AHCCCS claim number
- Date of payment
- Amount paid
- Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s) shall include a minimum of the following:

1. How the need for the recoupment was identified.
2. The process that will be utilized to recover the funds.
3. The anticipated timeline for the recoupment.
4. The Provider's right to file a claim dispute.
5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.
6. Listing of impacted claim numbers.

Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

Recoupment of Payments Initiated More Than 12 Months From the Date of Original Payment

The Division is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of *a clean claim* unless prior approval is obtained from AHCCCS. Retroactive recoveries involving commercial insurance payor sources are not included in this discussion. For Coordination of Benefits involving third party liability recoveries see *ACOM Policy 434 and the Division's Operations Manual Chapter 434 Coordination of Benefits & Third Party Liability.*

A. To request approval from AHCCCS, the Division submits a request in writing with all of the following information:

A detailed letter of explanation will be submitted with the following:

1. How the need for recoupment was identified.
2. The systemic causes resulting in the need for a recoupment.
3. The process that will be utilized to recover the funds.
4. Methods to notify the affected Provider(s) prior to recoupment.
5. The anticipated timeline for the project
6. The corrective actions that will be implemented to avoid future occurrences.
7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.

B. An electronic file containing the following:

- AHCCCS member ID
- Date of service
- AHCCCS claim number
- Date of payment
- Amount paid
- Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication includes at a minimum:

1. How the need for the recoupment was identified.
2. The process that will be utilized to recover the funds.

3. The anticipated timeline for the recoupment.

4. The Provider's right to file a claim dispute.

5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.

6. Listing of impacted claim numbers.

Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

The Division continuously tracks recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the Division reports the cumulative recoupment monthly as outlined in the AHCCCS Claims Dashboard Reporting Guide and as specified in the Division's contract.

AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of AHCCCS.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating factors such as validity, accuracy, and efficiency of the Division's processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing Provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Division by electronic mail contingent upon receipt of all required information from the Division.

Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Division has *no more than 120-days* to complete the project and submit the following as stated in the Division's contract:

A. Notification of the submission for the voided or replacement encounters (which reaches adjudicated status within 120-days of the approval of the recoupment) and the appropriate associated information for all impacted encounters for recouped claims.

B. Upon completion of the recoupment project, a separate electronic file containing all of the following information for all recouped claims (this is independent of the 837 file(s) submitted through Encounters):

- AHCCCS member identification number
- Date of service
- Original AHCCCS CRN
- New AHCCCS CRN

- Health Plan allowed amount
- Health Plan paid amount
- Provider identification number.

Note: The Division submits the above information for each adjudicated encounter. Dependent on the size and/or volume of the recoupment request, AHCCCS may require the Division to submit an external file in order to directly update impacted encounters in the timeframe prescribed above.

Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in administrative action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of amending the encounter data, AHCCCS may adjust related reinsurance payments, reconciliation payments, or any other amounts paid to the Division that are impacted by the recoupment.

Data Processes for Refunds

Upon receipt of refund from a Provider, the Division has 120-days from the date of the refund to void or replace related encounters. All voided or replaced encounters reaches an adjudicated status within the 120-day timeframe.

A. The Division identifies the following for all refunds received and provide this information to AHCCCS upon request:

1. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred.
2. The corrective actions that will be implemented to avoid future occurrences, if applicable.
3. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund.
4. List of impacted claim numbers.

Attestation

All documentation and data submitted by the Division for purposes of recoupment and refund activities certified by the Division as specified in 42 CFR 438.600 et seq. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Division failed to comply with any provisions of AHCCCS Policy 412 – Claims Recoupment, the Division may be subject to administrative actions.

414 REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

REVISION DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 U.S.C. 1396d(r)(5), 42 CFR 438.404(b)(2), 42 CFR 438.10(c)(4)(ii), ACOM Policy 414 , AMPM Policy 430

PURPOSE

This policy sets forth Division requirements for Notices of Adverse Benefit Determination relating to Title XIX/XXI coverage and authorization of services.

DEFINITIONS

1. "Adverse Benefit Determination" means the denial or limited authorization of a service request or the reduction, suspension, or termination of a previously approved service.
2. "Appeal" means a request for review of an Adverse Benefit Determination.
3. "Calendar Days" means every day of the week including weekends and holidays.
4. "Expedited Service Authorization Request" means a request for

services in which either the requesting provider indicates, or the Division determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.

5. "Legal Holidays" means Legal Holidays, as defined by the State of Arizona are:

   a. New Year's Day – January 1

   b. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January

   c. Lincoln/Washington Presidents' Day – 3rd Monday in February

   d. Memorial Day – Last Monday in May

   e. Independence Day – July 4

   f. Labor Day – 1st Monday in September

g. Columbus Day – 2nd Monday in October

h. Veterans Day – November 11

i. Thanksgiving Day – 4th Thursday in November

j. Christmas Day – December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

6. "Member" means the same as "Client" as defined in A.R.S. §36-551.

7. "Notice of Adverse Benefit Determination " means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the Division regarding the Service Authorization Request and includes the information required by this Policy.

8. "Notice of Extension" or "NOE" means a written notice to a Member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if the criteria

for a service authorization extension are met.

9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

10. "Service Authorization Request" means a request by the Member, the representative, or a provider for a physical or behavioral health service for the Member that requires Prior Authorization (PA) by the Division.

11. "Working days" means "Working Day" as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:

    a. A legal holiday falls on one of these days; or

    b. A legal holiday falls on Saturday or Sunday and the Division is closed for business the prior Friday or following

Monday.

POLICY

A. NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The Division shall provide a written Notice of Adverse Benefit Determination to the Responsible Person and the provider when the Division decides to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services .

2. The Division shall use the AHCCCS-developed Member Notice of Adverse Benefit Determination templates as specified in 42 CFR 438.10(c)(4)(ii).

    a. The templates shall not be altered except for the areas designated in the template that permit alteration and the removal of the header.

    b. Refer to ACOM Policy 414 Attachment A for the Notice of Adverse Benefit Determination template for Service Authorization Requests that do not pertain to medications.

3. The Division's Member Handbook shall inform the Responsible Persons:

   a. Of their right to make a complaint to the Division about an inadequate Notice of Adverse Benefit Determination;

   b. If the Division does not resolve the complaint about the Notice of Adverse Benefit Determination to the Responsible Person's satisfaction, the Responsible Person may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at MedicalManagement@azahcccs.gov; and;

   c. The Division and its providers shall be prohibited from taking punitive action against Responsible Persons exercising their right to Appeal.

   d. That the Division shall inform the Responsible Person that oral interpretation services are available in any language, and alternative communication formats are available for Responsible Persons that are deaf or hard of hearing or

blind or have low vision.

B. RIGHT TO BE REPRESENTED

1. The Division shall acknowledge the Responsible Person's right to be assisted by a third-party representative, including an attorney, during an Appeal of an Adverse Benefit Determination.

2. The Division shall have an Appeals process that registers the existence of the third-party representative.

3. The Division shall ensure the required communications related to the Appeals process occur between the Division and the third party representative.

    a. The Division shall provide the Responsible Person's third party representatives, upon request, timely access to documentation relating to the decision under Appeal.

    b. The Division shall be consistent with federal privacy laws by making reasonable efforts to verify the identity of the third party representative and the authority of the third

party representative to act on behalf of the Responsible Person.

c. The Division may require the third party representative to provide written authorization signed by the Responsible Person.

d. The Division shall promptly communicate to the Responsible Person when the Division questions the authority of the third party representative or the sufficiency of the written authorization.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

1. The Division shall provide a Notice of Adverse Benefit Determination that meets the language requirements as outlined in Division Operations Policy 404.

2. The Division shall provide a Notice of Adverse Benefit Determination that clearly explains the Member-specific reasons for the Division's determination and the information needed so

the Responsible Person can make an informed decision regarding Appealing the determination and how to Appeal the decision.

3. The Division shall clearly inform the Responsible Person when the reason for the Notice of Adverse Benefit Determination denial of a Service Authorization Request is due to the lack of necessary information, and will give the Responsible Person the opportunity to provide the necessary information.

4. The Division shall provide a Notice of Adverse Benefit Determination that is consistent with 42 CFR 438.404 and includes an explanation of the specific facts that pertain to the decision:

   a. The requested service;

   b. The level of service which which may include a request for an enhanced staffing ratio,

   c. The reason or purpose of the requested service;

   d. The reasons for the Adverse Benefit Determination the

Division made or intends to make with respect to the requested service consistent with 42 CFR 438.404(b)(1);

e. The effective date of a service denial, limited authorization, reduction, suspension, or termination;

f. The right of the Responsible Person to be provided, upon request and at no cost to the Responsible Person, reasonable access to and copies of all documents, records, and other information relevant to the Responsible Person's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2);

g. The legal basis for the Adverse Benefit Determination including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable, reference to the general legal authorities alone is unacceptable;

h. Where the Responsible Person can find copies of the legal basis:

i. Reference to the benefit provision, guideline, protocol, or other criterion which the denial is based upon.

ii. An accurate URL site, when a legal authority or an internal reference to the Division's policy manual is available online.

i. A listing of legal aide resources

j. The Responsible Person's right to request an Appeal and the procedures for filing an Appeal of the Division's Adverse Benefit Determination, including information on exhausting the Division's Appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c) including if the Division fails to make a decision in a timely manner regarding the Member's Appeal request;

k. The procedures for exercising the Responsible Person's rights as described in 42 CFR 438.404(b)(4);

l. The circumstances under which an Appeal process can be expedited and how to request it; and

m. Explanation of the Member's right to have benefits continue pending the resolution of the Appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Responsible Person may be required to pay the costs of continued services if the Appeal is denied as specified in 42 CFR 438.420(d), and

n. A statement that the provider who requested the Service Authorization has the option to request a peer-to-peer discussion with the Division's Medical Director.

i. The Division shall allow the provider sufficient time for a peer-to-peer to occur before the Division issues its decision regarding the Service Authorization

Request.

ii. The Division shall allow at least 10 business days for the provider to request a peer-to-peer review.

5. The Division shall not cite the lack of medical necessity as a reason for denial, unless the Notice of Adverse Benefit Determination also explains why the service is not medically necessary for the particular Member in this instance.

6. The Division shall include potential alternative options for consideration that may address the Member's condition when citing lack of medical necessity as a reason for the Adverse Benefit Determination.

7. The Division shall provide a Notice of Adverse Benefit Determination that states the reasons supporting the denial, reduction, limitation, suspension, or termination of a service.

8. The Division shall utilize a board-certified professional when citing lack of medical necessity and provide evidence of such

upon AHCCCS request.

9. The Division shall not provide a Notice of Adverse Benefit Determinations that does not give an explanation of why the service has been denied, reduced, limited, suspended, or terminated and merely refer the Responsible Person to a third party for more information.

10. The Division shall provide a Notice of Adverse Benefit Determinations that includes a statement referring a Responsible Person to a third party for more help when the third party can explain treatment alternatives in more detail.

D. EPSDT

1. The Division shall cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX Member who is younger than 21 years of age when these provisions are applicable and shall specify the reason(s) why the service fails to correct or ameliorate defects

or physical or behavioral health conditions or illnesses.

2. The Division shall explain the denial, reduction, limitation, suspension, or termination of the requested EPSDT service in accordance with AMPM 430 and this Policy.

3. The Division shall specify why the requested service does not meet the EPSDT criteria and is not covered.

4. The Division shall also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

E. RESPONSIBLE PERSON COMPLAINTS REGARDING THE ADEQUACY OR UNDERSTANDIBILITY OF THE NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The Division shall review the initial Notice of Adverse Benefit Determination against the content requirements of this Policy when a Responsible Person complains about the adequacy of a Notice of Adverse Benefit Determination.

2. The Division shall issue an amended Notice of Adverse Benefit Determination consistent with the requirements of this Policy when the Division determines the original Notice of Adverse Benefit Determination is inadequate or deficient.

3. The Division shall begin the timeframe for the Responsible Person to Appeal and continuation of services from the date of the amended Notice of Adverse Benefit Determination when an amended Notice of Adverse Benefit Determination is required.

F. TIMEFRAMES FOR SERVICE AUTHORIZATIONS

All references to "days" in this Policy mean "Calendar Days" unless otherwise specified.

1. The Division shall ensure completion and issuance of the service authorization decision when a Service Authorization Request is

submitted within the following timeframes, including requests that are standard requests and expedited requests.

a. The Division shall consider the date and time the Division or one of its AdSS' receives the request, whichever is earlier, to be considered the date and time of receipt.

b. The Division shall use the date and time to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The Division may use electronic date stamps or manual stamping for logging the receipt.

c. The Division shall make sufficient attempts to obtain the information or clarification and document all attempts for Service Authorization Requests lacking sufficient clinical information necessary to render the decision or the required clarification.

2. Standard authorization decision timeframe for Service Authorization Requests

a. The Division shall issue service authorization decisions as expeditiously as the Member's condition requires but no later than 14 Calendar Days from receipt of the request for the service regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

b. The Division may issue a NOE of up to 14 additional Calendar Days when the criteria for a service authorization extension are met as specified in section (H) of this Policy.

3. Expedited Service Authorization Decision Timeframe for Service Authorization Requests:

a. The Division shall issue an expedited service authorization decision, as expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and

Sunday) or legal holiday as defined by the State of Arizona.

b. The Division shall issue a NOE of up to 14 additional Calendar Days, when the criteria for a service authorization extension are met as specified in section (H) of this Policy.

4. Expedited Service Authorization Request treated as a standard request:

a. The Division shall treat the Expedited Service Authorization Request as a Standard Authorization Request when the Expedited Service Authorization Request fails to meet the requirements for expedited consideration.

b. The Division shall have a process included in the Division's policy for prior authorization (PA) that describes how the Responsible Person and provider shall be notified of the change to a standard authorization request and be given an opportunity to provide additional information, refer to

Provider Policy Manual Chapter 17.

c. The Division shall permit the requesting provider to send additional documentation supporting the need for an Expedited Service Authorization request.

5. Service authorization decisions not reached within the timeframes:

a. The Division shall consider a Service Authorization Request decision that is not reached within the required timeframes for a standard or expedited request, as a denial when the Division has not made a decision.

b. The Division shall issue a Notice of Adverse Benefit Determination denying the request on the date that the timeframe expires.

6. Service authorization decisions not reached within the extended timeframes:

a. The Division shall consider a Service Request Authorization

decision that is not reached within the timeframe noted in the NOE as a denial.

b. The Division shall issue a Notice of Adverse Benefit Determination denying the service request on the date that the timeframe expires as specified in 42 CFR 438.404(c)(5).

G. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

1. The Division shall mail the Notice of Adverse Benefit Determination within the following timeframes:

   a. For termination, suspension, or reduction of a previously authorized service, the Division shall mail the Notice of Adverse Benefit Determination at least 10 Calendar Days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice [42 CFR 431.211, 42 CFR 438.404(c)(1)];

b. For standard service authorization decisions that deny or limit services, the Division shall provide a Notice of Adverse Benefit Determination:

i. As expeditiously as the Member's health condition requires, but no later than 14 Calendar Days from the receipt of the request, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona, unless there is a NOE. For extension timeframes, refer to NOE requirements in this Policy [42 CFR 438.404(c)(3) and (4), 42 CFR 438.210(d)(1)];

ii. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless

there is a NOE. For extension timeframes, refer to NOE requirements in this Policy.

H. NOTICE OF EXTENSION (NOE) REQUIREMENTS

1. Notice of Extensions (NOE) Timeframes

   a. The Division shall extend the timeframe to make a service authorization decision for both standard and Expedited Service Authorization Requests when:

      i. The Responsible Person or provider, with the Responsible Person’s written consent, requests an extension, or

      ii. The Division shall document all attempts made to the requesting provider for the needed information.

      iii. The Division shall notify the Responsible Person of the reason for the extension and attempt to obtain the Member's approval before the Division pursues an extension due to lack of sufficient clinical

information.

2. The Division shall not pursue the NOE until the Division has made sufficient attempts to first obtain the necessary information from the Responsible Person or provider within the standard or expedited timeframe, whichever is applicable. Refer to 42 CFR 438.404(c)(4) and 438.210(d).

3. The Division shall document all attempts to obtain the necessary information.

4. The Division shall notify the Member of the reason for the extension and attempt to obtain the Member's approval before the Division pursues an extension due to lack of sufficient clinical information.

5. The Division shall not send the NOE until the Division has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)];

   a. For standard Service Authorization Requests, the Division

may extend the 14 Calendar Day time frame to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the service request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona;

b. For an Expedited Service Authorization Request, the Division may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona;

c. When the Division justifies the need for additional information is in the Member's best interest. The Notice of NOE shall not be sent until the Division has made sufficient attempts to obtain the necessary information from the Responsible Person [42 CFR 438.404(c)(6), 42 CFR

438.210(d)(2)(ii)].

d. For Standard Service Authorization requests, the Division may extend the 14-Calendar Day timeframe to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the Service Authorization Request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

e. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations in this Policy when the prior authorization requests lack sufficient information from the prescriber.

f. For an expedited Service Authorization Request (requests that do not involve medication), the Division may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the

due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

6. When the Division extends the timeframe to make a decision, in accordance with 42 CFR 438.210(d)(1) the Division shall:

   a. Provide the Responsible Person written notice of the reason for the decision to extend the timeframe, including what information is needed in order to make a decision, and in easily understood language, as outlined in Division Operations Policy 404;

   b. Inform the Responsible Person of the right to file a grievance or complaint if the Responsible Person disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and;

   c. Issue and carry out the decision as expeditiously as the Member's condition requires and no later than the date the extension expires consistent with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii).

415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

REVISION DATE: 1/17/2024, 3/22/2023

REVIEW DATE: 10/10/2023

EFFECTIVE DATE: October 1, 2018

REFERENCES: ACOM 415, 417, and 439; ACOM 415 Attachments A, B, D, F; ACOM 417 Attachment A, B; 9 A.A.C. 22, Articles 1 and 2; A.R.S. §§ 36-2901, 36-3407; 42 CFR 457.1230, 42 CFR 438.207(b), Section F3, Contractor Chart of Deliverables

PURPOSE

The purpose of this policy is to establish Division requirements for the Division's submission of the Network Development and Management Plan and other periodic network reports to AHCCCS.

DEFINITIONS

1. "Attachment" means attachment to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) 415.
2. "Contract" means the Division's contract with AHCCCS.

POLICY

A. NETWORK DEVELOPMENT AND MANAGEMENT PLAN

1. The Division shall develop and maintain a provider Network Development and Management Plan (NDMP) that assures AHCCCS that the provision of covered services will occur as stated in the Contract [42 CFR 457.1230, 42 CFR 438.207(b)].
2. The Division shall evaluate/review activity and performance during the Contract year prior to the NDMP's submission date and address the Division's plan for network development and related activity during the Contract year in which it was submitted.
3. The Division shall specify in the NDMP the process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.
4. The Division shall include in the NDMP a comprehensive description of elements identified in Attachment B and shall

submit as specified in Contract. In the submission, the Division shall include the following:

a. Attachment A, Network Attestation Statement.

b. Attachment B, Network Development and Management Plan Checklist, in Microsoft Word format.

c. Attachment F, the Centers of Excellence Checklist (COE), in Microsoft Word format.

d. The Centers of Excellence (COE).

B. PERIODIC NETWORK REPORTING

1. Provider Changes Due to Rates Report

   a. The Division shall submit Attachment D, as specified in Contract.

   b. The Division shall submit changes resulting in a material change to the network to AHCCCS as specified in ACOM Policy 439.

2. Service Delivery Standard Report

   a. The Division shall submit the Home and Community Based Services (HCBS) Service Delivery Standard Report as

specified in the Contract. The Division shall include the following in the report:

i. A description of the metrics used by the Division to measure the timeliness of its service delivery and its performance under those metrics,

ii. A summary of the Division's performance under these metrics, and

iii. A trended analysis of the current performance.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

Durable Medical Equipment (DME) Wheelchair Service Delivery Reporting;

Provider Network Development and Management Plan;

Provider/Network Changes Due to Rates Report Attachment D and E;

Centers of Excellence Attachment to Provider Network Development and Management Plan, HCBS Standard Delivery Report.

416 PROVIDER INFORMATION

REVISION DATE: 1/3/2024, 10/1/2019

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR 438.102

PURPOSE

This Policy establishes provider information requirements.

DEFINITIONS

1. "Americans With Disabilities Act" or "ADA" means the Americans with Disabilities Act of 1990, as amended, that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in 42 U.S.C. 126 and 47 U.S.C. 5.
2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical

and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources.

a. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.

b EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

c. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Home and Community Based Services" or "HCBS" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care.
    a. A PCP may be:
        i. A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17;
        ii. A practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25;
        iii. A certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or
        iv. A naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

b. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

6. "Provider" means any person or entity that contracts with the Division to provide a covered service to Members in accordance with A.R.S. § 36-2901.

7. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

8. "Value-Based Purchasing" or "VBP" means a payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals and measures in accordance with the VBP strategy selected for the contract.

   a. VBP is a non-encounterable payment and does not reflect payment for a direct medical service to a member.

   b. VBP payment will typically occur after the completion of the contract period but could include quarterly or semiannual payments if contract terms specify such

payments in recognition of successful performance measurement.

POLICY

A. PROVIDER MANUAL

1. The Division shall develop, distribute, and maintain a provider manual, ensuring that each contracted provider is made aware of the provider manual available on the Division's website or, if requested, issued a hard copy of the provider manual. The Division shall make available a provider manual to any individual or group that submits claim and encounter data.
2. The Division shall ensure that all providers, whether contracted or not, meet the applicable AHCCCS requirements that relate to covered services and billing.
3. The Division shall ensure that the provider manual provides information regarding the following:
    a. The ability of a member's Primary Care Provider (PCP) to treat behavioral health conditions within the scope of their practice.

b. Introduction to the Division that explains the Division's organization and administrative structure.

c. Provider responsibility and the Division's expectation of the provider.

d. Division's provider service departments and functions including the expected response times for provider inquiries.

e. Listing and description of covered and non-covered services, requirements, and limitations, including behavioral health services.

f. Appropriate and inappropriate use of the emergency department.

g. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

    i. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings, and immunizations.

ii. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.

h. Description of dental services coverage and limitations.

i. Description of maternity and family planning services.

j. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.

k. Process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

l. Grievance and appeal system process and procedures for providers and enrollees.

m. Billing and encounter submission information.

n. Policies and procedures relevant to the providers that contain:

i. Utilization management;

ii. Claims submission;

iii. Criteria for identifying provider locations that provide physical access, accessible equipment, and reasonable accommodations for Members with physical or cognitive disabilities; and

iv. PCP assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.

o. Procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, that contains:

i. Members' name,

ii. Members' date of birth,

iii. Members' AHCCCS ID,

iv. AHCCCS ID of the assigned PCP, and

v. Effective date of member assignment to the PCP.

p. Policies relevant to payment responsibilities that contain:

i. Description of the Change of Contractor policies as specified in ACOM Policy 401 and ACOM Policy 406, and

ii. Nursing Facility and Alternative Home and Community Based Service (HCBS) setting contract termination procedures as specified in ACOM Policy 421.

q. Reimbursement policies, including reimbursement for Members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

r. Cost sharing responsibility.

s. Explanation of remittance advice.

t. Criteria for the disclosure of member health information

u. Medical record standards.

v. Prior authorization and notification requirements, including a listing of services which most frequently used services which require authorization, and instructions on how to

obtain a complete listing of services that require authorization.

w. Requirements for out of state placement for members.

x. Claims medical review.

y. Concurrent review.

z. Coordination of Care requirements, including designation of an Employment Coordinator as the statewide point of contact for the referral of Members requesting employment services from the Division.

aa. Credentialing and re-credentialing activities.

bb. Fraud, waste, and abuse as specified in ACOM Policy 103.

cc. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.

dd. Minimum Required Prescription Drug List (MRPDL) information, including:

i. How to access the MRPDL, electronically or by hard copy upon request, and

ii. How and when updates are communicated.

ee. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including prior authorization and limits specified in AMPM Policy 310-V, the Contractor's monitoring process for prescribers in AMPM Policy 310-FF, and informed consent requirements in AMPM Policy 320-Q.

ff. AHCCCS appointment standards.

gg. Requirements pertaining to duty to warn and duty to report as specified in AMPM Policy 960.

hh. Submission requirements under the AHCCCS DUGless Portal Guide for behavioral health providers regarding their responsibilities for submitting to AHCCCS demographic information.

ii. Americans with Disabilities Act (ADA) and Title VI Of the Civil Rights Act of 1964 requirements, as applicable.

jj. Process providers use to notify the Division for changing an address, contact information, or other demographic information.

kk. Information on services available through the AHCCCS Provider Enrollment Portal and how to access the portal and how to update provider registration data including current population groups sets served.

ll. Eligibility verification.

mm. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964, and access to interpretation services for Members who speak a language other than English, including Sign Language.

nn. Peer review and appeal process.

oo. Medication management services as described in the contract.

pp. A Member's rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including, to:

i. Be treated with dignity and respect.

ii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

iii. Participate in treatment decisions regarding his or her health care, including the right to refuse treatment.

iv. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

v. Request and receive a copy of the medical records, and to request that the medical records be amended or corrected, as specified in 45 CFR part 164 and applicable state law.

vi. Exercise his or her rights and the exercise of those rights shall not adversely affect service delivery to the Member.

qq. Notification that the Division has no policies that prevent the provider from advocating on behalf of the Member as specified in 42 CFR 438.102.

rr. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

ss. General and informed consent for treatment requirements.

tt. Advance directives.

uu. Transition of members.

vv. Encounter validation studies.

ww. Incidents, accidents, and deaths reporting requirements as specified in AMPM Policy 960.

xx. A pre-petition screening, court ordered evaluations, and court ordered treatment.

yy. Behavioral health assessment and service planning requirements:

i. As specified in AMPM Policy 320-O;

ii. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650;

iii. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040;

iv. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P;

v. Partnership requirements with families and family-run organizations in the children and adult behavioral health system; and

vi. Peer support and recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

4. The Division shall include the following information in the provider manual:

a. Housing criteria for individuals determined to have an SMI,

b. Seclusion, restraint, and emergency response reporting requirements, and

c. The SMI grievance and appeal process.

5. The Division shall include guidance in the Provider Manual on which services are the responsibility of DDD qualified vendors and which services are the responsibility of providers contracted with the DDD subcontracted health plans, and directions on how providers unsure of these responsibilities can obtain guidance.

B. REQUIRED NOTIFICATIONS

1. In addition to the updates required in this section, the Division shall require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division shall provide prior notification.
2. The Division shall provide written or electronic communication to contracted providers in the following instances:
    a. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, the Division shall provide written notice of the reason for declining any written request for inclusion in the network.
    b. Material Changes - The Division shall notify providers in advance of any Material Change to the Provider Network or business operations as specified in ACOM policy 439.
    c. Division Policy and Procedure Changes – For any change in policy, process, or protocol including prior authorization, retrospective review, or performance and network standards that affects or can reasonably be foreseen to affect the Division’s ability to meet performance standards

of the Division contract with AHCCCS, the Division shall notify:

i. The designated operations compliance officer to which the Division is assigned, sixty calendar days before a proposed change, and

ii. Affected provider, thirty calendar days before the proposed change.

d. AHCCCS Guidelines, Policy, and Manual Changes - The Division shall notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals.

e. Division Provider Manual Changes - The Division shall notify its providers when modifications are made to the provider manual.

f. Subcontract Updates

i. If the AHCCCS Minimum Subcontract Provisions are modified, the Division shall issue a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts.

ii. The Division shall amend the affected subcontracts on their regular renewal schedule or within six calendar months of the update, whichever comes first.

g. Termination of Contract – The Division shall provide, or require its subcontractors to provide, written notice to hospitals and provider groups at least 90 calendar days prior to any contract termination, other than contracts between subcontractors and individual practitioners, without cause.

h. Disease and Chronic Care Management – The Division shall disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

417 APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING, AND REPORTING

REVISION DATE: 2/28/2024, 3/22/2023, 10/1/2019
REVIEW DATE: 10/10/2023
EFFECTIVE DATE: January 16, 2019
REFERENCES: 42 CFR 438.206; 42 CFR 438.206(b)(4); 42 CFR 438.206(c)(1)((i)-(vi); 42 CFR 438.207(b); 42 CFR 457.1230(a); A.R.S. § 8-512.01; ACOM 415; ACOM 417, ACOM 417 Attachments A and B.

PURPOSE

This policy outlines the Appointment accessibility and availability standards and the Division's oversight and monitoring of the Administrative Services Subcontractors (AdSS) to ensure compliance with the Division's network sufficiency requirements. This policy outlines the process for the Division to report Service Provider Appointment accessibility and availability to the Arizona Health Care Cost Containment System (AHCCCS).

DEFINITIONS

1. "1800 Report" means an AHCCCS-generated document, provided quarterly that identifies Primary Care Physicians (PCPs) with a

panel of more than 1800 AHCCCS Members.

2. "Appointment" means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or Service Provider in Service Provider and service categories identified in this policy.

3. "Network Development and Management Plan" or "NDMP" means a plan the Division develops and maintains to ensure the provision of covered services will occur as stated in the Contract. The Network Development and Management Plan (NDMP) specifies the Division process to develop, maintain, and monitor an adequate Service Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.

4. "Service Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.

5. "Urgent Care Appointment" means an Appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

A. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

B. APPOINTMENT STANDARDS FOR THE ADSS

1. The Division shall require adherence to service accessibility standards and the contractual Appointment standards contained in 42 CFR 457.1230(a) and 42 CFR 438.206.

2. The Division shall require a comprehensive Service Provider network that provides access to all services covered under the Contract for all Members of the Division.

3. The Division shall require contracted services be covered through an out of network Service Provider until a network Service Provider is contracted if the network is unable to provide medically necessary services required under the Contract.

4. The Division shall require adherence with using the results of Appointment standards, monitoring to validate it has an adequate network of Service Providers ensuring timely service

coverage, and to reduce unnecessary emergency department utilization.

5. The Division shall require adherence with having written policies and procedures about educating it's Service Provider network regarding Appointment time requirements.

6. The Division shall require:

   a. A corrective action plan be developed when Appointment standards are not met.

   b. A corrective action plan be developed in conjunction with the Service Provider when appropriate.

C. GENERAL APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following Appointment standards are met:

1. For primary care Service Provider Appointments:

   a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition

requires but no later than two business days of request, and

b. Routine care Appointments scheduled within 21 calendar days of request.

2. For specialty Physician Appointments, including dental specialists:

a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days from the request, and

b. Routine care Appointments scheduled within 45 calendar days of referral.

3. For dental Service Provider Appointments:

a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than three business days of request.

b. Routine care Appointments scheduled within 45 calendar days of request.

4. For maternity care Service Provider Appointments:

Initial prenatal care Appointments for enrolled pregnant Members provided as follows:

a. First trimester, Appointments scheduled within 14 calendar days of request;

b. Second trimester, Appointments scheduled within seven calendar days of request;

c. Third trimester, Appointments scheduled within three business days of request; and

d. High risk pregnancies, Appointments scheduled as expeditiously as the Member's health condition requires and no later than three business days of identification of high risk by the AdSS or maternity care Service Provider, or immediately if an emergency exists.

D. PSYCHOTROPIC MEDICATION APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following psychotropic medication Appointment standards are adhered to:

1. Assess the urgency of the need immediately; and
2. Provide an Appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the Member:
   a. Does not run out of needed medications; or
   b. Does not decline in the Member's behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

E. GENERAL BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following general behavioral health

Appointment standards are met:

1. For behavioral health Service Provider Appointments:

   Urgent need Appointments scheduled as expeditiously as the Member's health condition requires but no later than 24 hours from identification of need.

2. Initial assessment:

   Scheduled within seven calendar days after the initial referral or request for behavioral health services.

3. Initial Appointment:

   a. Scheduled within time frames indicated by clinical need.

   b. Scheduled no later than 23 calendar days after the initial assessment for Members age 18 years or older; and

   c. Scheduled no later than 21 days after the initial assessment for Members under the age of 18

years old.

4. Subsequent behavioral health services:

Scheduled as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

F. BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR PERSONS IN LEGAL CUSTODY OF THE ARIZONA DEPARTMENT OF CHILD SAFETY (DCS) AND ADOPTED CHILDREN

1. The Division shall require the following Appointment standards are met:

a. Rapid response:

When a child enters out-of-home placement within the time frame indicated by the behavioral health condition, but no later than 72 hours after notification by the Arizona Department of Child Safety (DCS) that a child has been or will be removed from their home;

b. Initial assessment:

Within seven calendar days after the initial referral or request for behavioral health services;

c. Initial Appointment:

Within time frames indicated by clinical need, but no later than 21 calendar days after the initial assessment; and

d. Subsequent behavioral health services:

Within the time frames according to the needs of the person, but no longer than 21 calendar days from the identification of need.

2. The Division shall require Appointment standards for Members in the legal custody of the DCS and adopted children are adhered to in order to to monitor Appointment accessibility and availability. .

G. SERVICE PROVIDER APPOINTMENT AVAILABILITY REVIEW FOR THE ADSS

1. The Division shall require regular reviews of Service Providers

are conducted to assess the availability of routine and Urgent Appointments for primary care, specialist, dental, and behavioral health Service Providers for Members in the legal custody of the Department of Child Safety (DCS) and adopted children.

2. The Division shall require the review of the availability of routine and urgent Appointments for maternity care Service Providers relating to the first, second and third trimesters, and high risk pregnancies.

3. The Division shall consider an Appointment available to be delivered through telehealth as an available Appointment where clinically appropriate.

4. The Division shall require Service Provider Appointment availability reviews be conducted as a method to ensure sufficient Service Provider network capacity.

5. The Division shall require Provider Appointment availability reviews be conducted for all Service Providers or a statistically relevant sample of Service Providers throughout the Contract year.

6. The Division shall require only using one of these methods at a time for conducting reviews:
   a. Appointment schedule review that independently validates Appointment availability;
   b. Secret shopper phone calls that anonymously validate Appointment availability; or
   c. Other methods approved by AHCCCS .
7. The Division shall supplement the monitoring efforts prescribed in (F)(1) through (F)(6) by targeting specific Providers identified through the following performance monitoring systems:
   a. The 1800 Report,
   b. Quality of care concerns,
   c. Complaints,
   d. Grievances, or
   e. The credentialing process.
8. The Division shall require any plans to change existing methodologies for Appointment availability reviews be submitted

to the Division for approval in the annual NDMP as specified in ACOM Attachment 415-B.

9. The Division shall submit this request to AHCCCSa as specified in the Contract.

H. TRANSPORTATION TIMELINESS REVIEW FOR THE ADSS

1. The Division shall monitor for adherence that medically necessary, non-emergent transportation is provided so a Member arrives on time for an Appointment, but no sooner than one hour before the Appointment, nor have to wait no more than one hour after the conclusion of the treatment for transportation home.

2. The Division shall require the following AHCCCS performance target is met: 95% of all combined completed pickup and drop off trips in a quarter are completed in the time frame specified in section (G)(1) above.

3. The Division shall require compliance with these standards be evaluated on a quarterly basis for all subcontracted transportation vendors orbrokers and require corrective action if

standards are not met.

4. The Division shall require adherence with transportation timeliness standards be monitored.

5. The Division shall require tracking for all scheduled trips that were not completed.

I. TRACKING AND REPORTING FOR THE ADSS

1. The Division shall require adherence in tracking Service Provider compliance with Appointment availability and transportation timeliness as specified in the Contract, the F3 Chart of Deliverables, and outlined below in sections (H)(2) through (H)(4).
2. The Division shall require a cover letter be submitted to AHCCCS with ACOM Attachment 417-A, including all of the following:
    a. A description of the methods used to collect the information;
    b. An explanation of whether all Service Providers in their network or a sample is being surveyed.

c. A sample of the Provider network needs to include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level;

d. A summary of the findings and an explanation of trends in either a positive or negative direction;

e. An analysis of the potential causes for these findings and trends.

f. A description of any interventions applied to areas of concern including, any corrective actions taken.

3. The Division shall require ACOM Attachment 417-B is submitted for each line of business, with a cover letter for each submission including all of the following:

a. A summary of the findings including any identified positive or negative trends for timeliness, incomplete trips, and their reason;

b. An analysis of the potential causes for these findings and

trends; and

c. A description of any interventions applied to areas of concern including, and corrective actions taken.

4. The Division shall require additional corrective action steps are provided for any reporting quarter where the average percentage of all completed trips for that quarter falls below the performance target of 95%. These steps shall include a timeline to meet the performance target of 95% of trips being completed in the time frame specified in section (G)(1) above.

5. The Division shall submit to AHCCCS a copy of ACOM Attachment 417-A and ACOM Attachment 417-B, for each of their AdSS.

6. The Division shall submit to AHCCCS a cover letter containing the information as specified in sections (H)(2) and (H)(3) and their subsections above related to each of their AdSS.

7. The Division shall annually require as a component of the NDMP, the following:

a. Conduct a review of the network sufficiency when there

has been a significant decrease in Appointment availability performance over the previous year;

b. Compare the annual average performance to the previous Contract year's average performance for each standard, Service Provider type and Appointment type subcategory specified within this Policy under the sections for General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards; and

c. Conduct a review of the sufficiency of the Service Provider network for any standard that decreased by more than five percentage points.

SUPPLEMENTAL INFORMATION

For additional information on behavioral health services and behavioral health standards for persons in the legal custody of the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. § 8-512.01, refer to AdSS Policy 449.

418 PROVIDER AND AFFILIATE ADVANCES, EQUITY DISTRIBUTIONS, LOANS, & INVESTMENTS

EFFECTIVE DATE: April 29, 2019

REFERENCES: ACOM 418 Provider and Affiliate Advances, Equity Distributions, Loans, and Investments.

Purpose

This Policy applies to Department of Developmental Disabilities (the Division). This Policy establishes requirements for Division regarding advances, equity distributions loans, loan guarantees, and investments; including but not limited to,–those to providers and related–parties or affiliates including another fund or line of business within the Division's organization.

Definitions

A. Advance - Includes but is not limited to payment to a provider or affiliate by a Contractor which is based on an estimate of Received but Unpaid Claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the Contractor.

B. Affiliate (Related Party) - A party that has, or may have, the ability to control or significantly influence a Division, or a party that is, or may be, controlled or significantly influenced by a Division. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Division and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

C. Affiliate (Related Party) Transactions - Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

D. Day - Calendar day unless otherwise specified.

E. Provider - Any individual or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901

Policy

AHCCCS reserves the right to evaluate and present all proposed Advances, equity distributions, loans, loan guarantees, and investments to the affected Providers(s), related parties, or Affiliates as part of the approval and/or notification process.

All requests must be submitted as specified in the Division Contract. AHCCCS will evaluate all requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. A written determination will be sent to the Division upon review of all required information from the Division.

Provider Advances, loans, and loan guarantees under $50,000 do not require prior AHCCCS approval but will be tracked and made available to AHCCCS upon request. AHCCCS reserves the right to request tracking logs, collection policies, and any pertinent information for all Advances, loans, or loan guarantees.

Individual and Cumulative Provider Advances, Loans, and Loan Guarantees

The Division must submit written notification to AHCCCS of any individual or cumulative Provider loans, loan guarantees, and Advances equal to or in excess of $50,000 per Provider Tax Identification Number (TIN) within a contract year. All requests for prior approval are to be submitted as specified in the Division contract. Prior approval requests must be submitted 10 Days prior to the anticipated date of distribution. All requests for approval must be in the format detailed below:

A. A detailed letter of explanation must be submitted that describes:

1. The Provider(s) name(s) and AHCCCS Identification Number(s),
2. The date the Provider and the Division initiated discussions relating to the need for the loan.
3. The systemic organizational causes resulting in the need for a loan including any mitigation strategies implemented prior to the request.
4. The process that will be used for repayment including the timeline,
5. The contingency plan for repayment should the Provider default on repayment,
6. The corrective action(s) that will be implemented to avoid future occurrences,
7. The total loan amount, and if applicable, the percentage that the Advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.
8. A copy of the written communication that will serve as notification to the affected Provider(s).

B. Upon completion of repayment or six months from the date of AHCCCS approval, whichever comes first, the Division will provide the following information to AHCCCS:

- Provider Name
- AHCCCS Provider ID
- Provider Tax Identification Number
- Date of Payment

- Amount Paid
- Amount Loaned
- Balance Due to/from the Provider

Required documentation for loan guarantees will be determined on an individual basis and communicated to the Division as part of the approval.

Routine or Scheduled Advances, Loans to Providers and Any Advances, or Loans to Affiliates

Routine/scheduled Advances or loans to Providers as a result of contractual arrangements or any Advance or loans to an Affiliate must be submitted to AHCCCS for prior approval. The request for approval must be submitted as specified in the Division contract.

AHCCCS may request additional information or periodic reconciliations related to these Advances.

Routine or Scheduled Advances, Equity Distributions, Loans, Loan Guarantees to Affiliates

The Division must submit a written request for approval to AHCCCS for any Advances, equity distributions, loans, loan guarantees or investments in /to related parties or Affiliates. This includes other funds or lines of business within its organization, within a contract year. Prior approval requests must be submitted 30 days prior to the anticipated date of distribution.

All approval requests must be in the format detailed below:

A. A detailed letter of explanation must be submitted that describes:

- The Related Party or Affiliate Name
- The Amount
- The Type of Request
- The Purpose or Reason for Request
- The Expected Date of Investment or Distribution.

426 CHILDREN'S REHABILITATIVE SERVICES APPLICATION, DESIGNATION AND COVERAGE

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 36-2912; A.A.C. R9-22-1301, A.A.C. R9-22-1302, A.A.C. R9-22-1305

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual Policy 426 Children's Rehabilitative Services Application, Designation and Coverage for the Division policy governing AdSS responsibilities regarding this topic.

431 COPAYMENT

EFFECTIVE DATE: March 25, 2020

Members eligible with the Division of Developmental Disabilities and the ALTCS Program must not be billed copayments for any medical service, including prescriptions. Members are exempt from mandatory and optional copayments.

433 MEMBER IDENTIFICATION CARDS

EFFECTIVE DATE: December 21, 2022
REFERENCES: ACOM Policy 433

PURPOSE

This policy establishes the Division of Developmental Disabilities (Division) requirements regarding the development, approval and distribution of Member Identification Cards (ID Cards) and replacement ID Cards.

DEFINITIONS

1. "834 Enrollment Transaction File" means a nightly transaction file provided by Arizona Health Care Cost Containment System (AHCCCS) to its Contractors. The file identifies newly enrolled members and enrollment changes for existing members.

POLICY

A. PROGRAMMING REQUIREMENTS

1. The Division shall determine the timeliness for issuing ID Cards when a new AdSS initiates services in the state.

2. The Division shall ensure the AdSS provides members with new ID Cards at least 14 calendar days prior to a new DDD health plan going into effect.
3. The Division shall approve the format for a combined ID Card for members dually enrolled in Medicare and the Division. The format for the combined ID Cards must:
    a. Meet the Centers for Medicare and Medicaid Services (CMS) requirements for ID Cards and be approved AHCCCS.
    b. Meet the minimum formatting requirements identified in ACOM Policy 433 Attachment A as applying to ID Cards for members dually enrolled.
    c. Adopt additional formatting features included in this policy or prescribed by CMS for the requirement of an ID Number, if the formatting does not conflict with this policy's minimum requirements.

B. FORMAT OF MEMBER IDENTIFICATION CARDS (ID CARDS)

1. The Division shall ensure ID Cards must meet the format standards outlined in this policy or as specified in ACOM Policy 433 Attachment A. The following formatting standards apply:
   a. The front of the ID card shall include:
      i. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version.
      ii. AHCCCS Logo in the approved color or black and white version no smaller than 1” long by .333” inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The AdSS must not edit or alter the approved logo, except as noted above.
      iii. Arizona Health Care Cost Containment System in Arial font no smaller than 11 points.
      iv. The following information in Arial font no smaller than 8 points:
         1) Member’s name
         2) AHCCCS ID number

3) AdSS name

4) AdSS telephone number

5) TTY/TDY telephone number for members who are deaf or hard of hearing

6) Telephone number for accessing services from the Behavioral Health services

7) The nurse triage telephone number

8) ACC-RBHA statewide crisis phone number

b. The back of the ID card includes:

i. In Arial font no smaller than 7 points:

1) The following text: "Carry this card with you at all times. Present it when you get services. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify health plan benefits, visit: UnitedHealthcare Plan – www.uhc.com

Mercy Care Plan – www.mercycareaz.org

DDD Tribal Health Program (THP) –

DDD Customer Service 1-844-770-9500 ext. 7

2) The following text in the card's mailing to the member if a card holder is not used: "To help protect your identity and prevent fraud, AHCCCS is adding pictures to its online verification tool that providers use to verify your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details."

c. The Division may include additional information on the ID card or card holder identified as appropriate, subject to the approval requirements of this policy.

d. The Division shall include the most recent version of the AHCCCS Notice of Privacy Practices (NPP) with any new ID Card mailing.

C. APPROVAL OF MEMBER IDENTIFICATION CARDS, AND OTHER COMPLIANCE REQUIREMENTS

1. The Division shall ensure the ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items are submitted for prior approval by the AdSS.
2. The Division shall approve ID Cards and other member information for their AdSS subcontractors.
3. The Division shall ensure the AdSS obtains prior approval if more than one version of an ID Card is issued to members.
4. The Division shall ensure the card holder and any letters or information mailed to the member with the ID Card complies with requirements as specified in AdSS Operations Manual, Policy 404.

435 TELEPHONE PERFORMANCE STANDARDS AND REPORTING

REVISION DATE: 03/22/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 435; Attachment A.

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Customer Service Center (CSC). This Policy establishes the Division's standards and reporting requirements regarding the Division's performance when handling Member and provider telephone calls.

DEFINITIONS

1. "Average Speed of Answer (ASOA)" means the average online wait time in seconds that the Member/provider waits from the moment the call is connected in the Division's CSC phone switch until the call is picked up by a Division CSC's representative or Interactive Voice Recognition System.
2. "Daily First Contact Call Resolution Rate (DFCCR)" means the number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed,

divided by the total number of calls received in the 24-hour period.

3. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
4. "Member Grievance" means an expression of dissatisfaction from a Member, responsible party, advocate, etc., with any aspect of a Member's care other than an adverse benefit determination.
5. "Member Inquiry" means a question, request for guidance or direction from a Member, responsible party, advocate, etc., with any aspect of a Member's care other than an adverse benefit determination.
6. "Monthly Average Abandonment Rate (MAAR)" means this is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.
7. "Monthly Average Service Level (MASL)" means the total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls

abandoned calls in the month and all calls receiving a busy signal in the month (if available).

8. "Monthly First Contact Call Resolution Rate (MFCCR)" means the sum of the DFCCRs divided by the number of business days in the reporting period.
9. "Provider Grievance" means a provider's expression of dissatisfaction with unresolved issues. and claims that are older than 30 days from the day of billing.
10. "Provider Inquiry" means any question related to provider matters or issues that can be resolved within the first call or email in less than 30 days, and billing issues including claims less than 30 days from the day of billing.

POLICY

A. TELEPHONE PERFORMANCE STANDARDS

The CSC shall adhere to the following Telephone Performance Standards for Member and provider calls on a monthly basis:

1. The ASOA shall be 45 seconds or less.
2. The MAAR shall be 5% or less.
3. The MFCCR shall be 70% or better.

4. The MASL shall be 75% or better.

B. TELEPHONE PERFORMANCE MEASURES REPORT

1. The CSC shall track performance based on standards noted above and report performance results to the DDD OIFA Administrator.
2. The CSC shall separately document performance for calls of the following types:
   a. Member Calls, and
   b. Provider Calls.
3. The CSC shall submit a monthly Telephone Performance Measures Report to the OIFA Administrator within 15 days after the reporting month.
4. The CSC, if non-compliant with any standard on this deliverable for any given month, shall include in the report steps the CSC shall follow to reduce the noncompliant performance.
5. The CSC shall notify the DDD AHCCCS Contract Compliance Officer when there are unanticipated telephone service interruptions in the toll-free phone system.

C. MEMBER INQUIRIES

1. The CSC shall document all incoming Member Inquiries.
    a. All incoming Member Inquiries shall be resolved within the first communication.
    b. If the issue needs additional follow-up for resolution or assistance, the CSC shall treat it as a Member Grievance.

D. PROVIDER INQUIRIES

1. The CSC shall document all incoming Provider Inquiries.
2. The CSC shall resolve all incoming Provider Inquiries within 30 days from the date of receipt of the inquiry.
3. The CSC shall treat inquiries not resolved within 30 days as a Provider Grievance.
4. The CSC shall identify systemic issues, if any, and document them.
5. The CSC shall inform and elevate systemic issues to the OIFA Administrator, CSC Administrator, and the functional area Deputy Assistant Director or designee.

436 NETWORK STANDARDS

REVISION DATES: 3/27/2024, 4/26/2023, 10/1/2019, 1/16/2019

REVIEW DATE: 9/12/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 § C.F.R. 438.206(b)(1); A.R.S. §§ 32-1201, 32-1901, 36-401 et seq, 36-421 et seq; A.A.C. R9-10, R9-10-101, R9-10-801 et seq, R9-22-101, R9-33-101; ACOM 415; ACOM 436; ACOM 438

PURPOSE

This policy applies to the Division's Network staff. This policy outlines Division Network Standards and the oversight and monitoring of Network Standards.

DEFINITIONS

1. "Adult Developmental Home" or "ADH" means an Alternative Home and Community Based Service (HCBS) Setting for adults (18 or older) with Developmental Disabilities (DD) which is licensed by the Department of Economic Security (DES) to provide room, board, supervision and coordination of habilitation and treatment for up to three residents as specified in A.R.S § 36-551.

2. "Assisted Living Center" or "ALC" means an assisted living facility that provides resident rooms or residential units to eleven or more residents as specified in A.R.S. § 36-401.
3. "Assisted Living Facility" or "ALF" means a residential care institution that provides supervisory care services, personal care services, or directed care services on a continuing basis in compliance with Arizona Department of Health Services (ADHS) licensing criteria as specified in 9 A.A.C. 10, Article 8.
4. "Assisted Living Home" or "ALH" means an ALTCS approved alternative home and community based services (HCBS) setting that provides room and board, and supervision, and coordination of necessary services to 10 or fewer residents.
5. "Attachment A" means, for the purpose of this policy, the ACOM Policy 436 Attachment A - Minimum Network Requirements Verifications Template document that specifies the Network Standards in which the Division and the AdSS are required to meet.
6. "Behavioral Health Outpatient and Integrated Clinic, Adult" means a class of healthcare institution without inpatient beds

that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are age 18 and above

7. "Behavioral Health Outpatient and Integrated Clinic, Pediatric" means a class of healthcare institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are under 18 years of age.
8. "Behavioral Health Residential Facility" or "BHRF" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
    a. Limits the individual's ability to be independent, or
    b. Causes the individual to require treatment to maintain or enhance independence.
9. "Cardiologist, Adult" means a medical doctor who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system or patients aged 18 and above.

10. "Cardiologist, Pediatric" means a medical doctor who specializes in the study or treatment of heart diseases and heart abnormalities for patients under the age of 18.
11. "Dentist, Pediatric" means a medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. § 32-1201 for patients under the age of 18.
12. "District" or "Service District" means a section of Maricopa or Pima County defined by zip code for purposes of establishing and measuring minimum Network Standards for Developmentally Disabled (DD) Group Homes and Assisted Living Facilities.
13. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
14. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a

Member enrolled with that Contractor of record, as specified in 9 A.A.C. 22, Article 1 and 9 A.A.C. 28, Article 1.

15. "Group Home" means a community residential setting for not more than six individuals with intellectual/developmental disabilities, that provides room and board and daily rehabilitation and other assessed medically necessary services and supports to meet the needs of each individual as specified in A.R.S. § 36-551.

16. "Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

    a. Health care institution as specified in A.R.S. § 36-401;

    b. Residential care institution as specified in A.R.S. § 36-401;

    c. Community residential setting as specified in A.R.S. § 36-551; or

d. Behavioral health facility as specified in 9 A.A.C. 20, Articles 1,4,5, and 6.

17. "Hospital" means a class of healthcare institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient. Refer to A.A.C. R9-10-101 et seq. and A.R.S. § 36-401-437.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Multi-Specialty Interdisciplinary Clinic" or "MSIC" means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
20. "Network" means physicians, health care Providers, suppliers and hospitals that contract with an AdSS to give care to Members.
21. "Network Standards" means, as defined in ACOM 436, the requirements the Division and AdSS must meet and monitor to

ensure that all covered services are available and accessible to Members.

22. "Nursing Facility" means, as defined in 42 § U.S.C. 1936r(a):

    a. An institution or a distinct part of an institution that:

        i. Is primarily engaged in providing to residents:

            a) Skilled nursing care and related services for residents who require medical or nursing care;

            b) Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals; or

            c) On a regular basis, health-related care, and services to individuals who, because of their mental or physical condition, require care and services above the level of room and board that can be made available to them only through institutional facilities.

        ii. Is not primarily for the care and treatment of mental diseases; and

        iii. Has in effect a transfer agreement, meeting the requirements of 42 § U.S.C. 1861(l), with one or

more hospitals having agreements in effect under 42 § U.S.C. 1866.

b. Any facility that is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of a Nursing Facility outlined in this section.

23. "Obstetrician/Gynecologist" or "OB/GYN" means a healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs or who possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders.

24. "Pharmacy" means a facility regulated by the State Board of Pharmacy and operating under A.R.S. § 32-1901.

25. "Primary Care Provider (PCP), Adult" means a person who is responsible for the management of the health care of Members who are over 21 years of age. A PCP may be a:

a. Person licensed as an allopathic or osteopathic physician;

b. Practitioner defined as a licensed physician assistant; or

c. Certified nurse practitioner.

26. "Primary Care Physician (PCP), Pediatric" means a doctor or healthcare practitioner who is responsible for the management of the health care of Members who are under 21 years of age.
27. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.
28. "Provider Affiliation Transmission" or "PAT" means a data file that provides details of the Providers within the AdSS's Network and is used to measure compliance with Network adequacy requirements.

POLICY

A. The Division shall monitor and oversee the AdSS for the minimum Network Standards.

B. The Division shall have a Network of Providers in place to meet the minimum Network Standards..

C. The Division shall assess its Network against its entire membership for the purposes of complying with Network Standards, unless otherwise noted.

D. STATEWIDE NETWORK DEFINITIONS AND STANDARDS

1. The Division shall maintain a sufficient Network of Providers to meet the service needs of its Members based upon the minimum Network requirements specified in Attachment A and as specified in the DES/DDD contract with AHCCCS.
2. If the Division delegates Network activities, the Division shall ensure subcontractor compliance with applicable Network Standards.
3. The Division shall document a sufficient Network to meet the service needs of its Members based upon the minimum Network requirements delineated in Attachment A.
4. The Division shall use the table below for defining its Network of Assisted Living Center (ALC), Assisted Living Home (ALH), and DD Group Home Providers to measure compliance with Network Standards:

Provider Category	Applies to	Required Provider Type	Member Population	Standard
Assisted Living Centers (ALC)	ALTCS E/PD and DES/DDD only	49	All	See Attachment A, ALTCS County Tables
Assisted Living Home (ALH)	ALTCS E/PD and DES/DDD only	36	All	See Attachment A, ALTCS County Tables
Group Home for persons with	DES/DDD only	25	All	See Attachment A, ALTCS County

Developmental Disabilities				Tables

5. The Division shall have contracts with a minimum number of DD Group Homes as specified in Attachment A, ALTCS County tables.
6. The Division shall have contracts with a minimum number of ALC and ALH Providers as specified in Attachment A.
7. The Division shall utilize the Attachment A tab that details the minimum Network requirements in each county to report the following minimum Network requirements:
    a. Minimum contracts within a specific city or group of cities;
    b. Contracts within specified distances to specific cities;
    c. Minimum contracts within a county; and
    d. Contracts in locations outside of a county's boundary, if applicable.
8. The Division shall allow Members to access services in the most geographically convenient location possible and to prevent

Members from traveling much greater distances to obtain care, but at the same time accommodate Network availability in each county.

E. COUNTY AND DISTRICT DEFINITIONS

1. The Division shall establish and measure minimum Network Standards for DD Group Homes, ALCs, and ALHs in Maricopa and Pima Counties by utilizing the table of AHCCCS county and District definitions below:

   a. Maricopa County

MARICOPA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Phoenix	85022, 85023, 85024, 85027, 85029, 85032, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331
DISTRICT 2	Carefree, Cave Creek, Fountain	85250, 85251, 85255, 85256, 85257, 85258,

	Hills and Scottsdale	85259, 85260, 85262, 85263, 85264, 85268
DISTRICT 3	Phoenix	85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, 85051, 85253
DISTRICT 4	Phoenix	85003, 85004, 85006, 85007, 85008, 85009, 85025, 85034, 85040, 85041, 85042, 85044, 85045, 85048
DISTRICT 5	Buckeye, Goodyear, Phoenix, Tolleson and Gila Bend	85031, 85033, 85035, 85037, 85043, 85322, 85323, 85326, 85338, 85339, 85353, 85337
DISTRICT 6	Glendale	85301, 85302, 85303,

		85304, 85305, 85306, 85308, 85310
DISTRICT 7	El Mirage, Peoria, Sun City, Sun City West, Surprise and Wickenburg	85275, 85307, 85309, 85335, 85340, 85342, 85345, 85351, 85355, 85361, 85363, 85373, 85374, 85375, 85379, 85381, 85382, 85383, 85387, 85388, 85390, 85395, 85396
DISTRICT 8	Mesa, Tempe	85120, 85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282

DISTRICT 9	Chandler, Tempe, Gilbert, Queen Creek and Sun Lakes	85140, 85142, 85143, 85222, 85224, 85225, 85226, 85233, 85234, 85242, 85243, 85248, 85249, 85283, 85284, 85296, 85297

b. Pima County

PIMA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Northwest	85321, 85653, 85658, 85701, 85704, 85705, 85737, 85739, 85741, 85742, 85743, 85745, 85755
DISTRICT 2	Northeast	85619, 85702, 85712, 85715, 85716, 85718, 85719, 85749, 85750
DISTRICT 3	Southwest	85601, 85614, 85622,

		85629, 85713, 85714, 85723, 85724, 85735, 85736, 85746, 85757
DISTRICT 4	Southeast	85641, 85706, 85708, 85710, 85711, 85730, 85747, 85748

2. The Division shall calculate compliance with minimum Network Standards specified in ACOM 436.

F. NETWORK STANDARD EXCEPTION REQUESTS

1. When the Division has exhausted its efforts to meet any Network Standard specified in this policy, the Division shall request an exception to the Network Standards from AHCCCS as specified in ACOM Policy 436 and the DES/DDD contract that includes the following required elements:
   a. The county or counties covered under the exception request;
   b. The Provider types covered under the exception request;

c. A geospatial analysis showing the current Member access to the Provider types and counties covered under the exception request;

d. An explanation describing why the Division cannot meet the established Network Standard requirements;

e. An explanation of the efforts to contract with non-contracted Providers who could bring the Division into compliance with the Network Standard, including a discussion of the appropriateness of the rates offered to non-contracted Providers;

f. The Division's proposal for monitoring and ensuring Member access to services offered by Provider types under the exception request; and

g. The Division's plan for periodic review to identify when conditions in the exception area have changed, and the exception is no longer needed.

2. The Division, when all efforts to meet Network Standards have been exhausted, shall submit an exception to the Network Standards using the following criteria:

a. The total number of Providers in the same specialty practicing in the county;

b. The geographic composition of the county;

c. Provider willingness to enter into a contract;

d. Consideration of the rates offered to non-contracted Providers to bring the Division into compliance with the standard;

e. The availability of Indian Health Services 638 (IHS/638) contract facilities available to the American Indian population in the county;

f. The availability of alternative service delivery mechanisms available, such as telemedicine, Telehealth, or virtual or mobile services; and

g. The Division's proposal for monitoring and ensuring Member access.

SUPPLEMENTAL INFORMATION

A. MONITORING AND OVERSIGHT OF AdSS NETWORK STANDARDS

1. The Division shall monitor the AdSS to ensure the AdSS has a Network in place for each county in the AdSS's assigned service

area to meet the time and distance standards specified in the table below:

PROVIDER CATEGORY	REQUIRED PROVIDER/SPECIALTY TYPE(S)
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	77 or IC
Behavioral Health Residential Facility (BHRF)	B8
Cardiologist, Adult	08 or 31 with a Specialty Code of 062 or 927
Cardiologist, Pediatric	08 or 31 with a Specialty Code of 062, 151, or 927
Crisis Stabilization Facility	02, 71,B5, B6, B7, or 77 and ICs that are authorized to provide behavioral health observation/stabilization in

	accordance with A.A.C. 9-10-1012
Dentist, Pediatric	07 with a Specialty Code of 800 or 804, C2 Federally Qualified Health Centers (FQHCs) identified by AHCCCS
Hospitals	02 or C4
Nursing Facilities	22
Obstetrician/Gynecologist (OB/GYN)	08, 19, 31, or CN with a Specialty Code of 089, 090, 091, 095, 181, or 219
Pharmacy	03 or 05
Primary Care Provider (PCP), Adult	08 or 31 with a Specialty Code of 050, 055, 060, 089, or 091 or
	19, CN with a Specialty Code of

	084, 095, or 097 or
	18 with a Specialty Code of 798
Primary Care Provider (PCP), Pediatrics	08 or 31 with a Specialty Code of 050 , 150, or 176 or
	19, CN with a Specialty Code of 084 , 087, or 097 or
	18 with a Specialty Code of 798

2. The Division shall monitor for subcontractor compliance with applicable Network Standards if the AdSS delegates Network activities.
3. The Division shall refer to the table below for monitoring AdSS compliance with the following time and distance standards:

PROVIDER CATEGORY	APPLIES TO	MEMBER POPULATION	COUNTY	STANDARD (90% of membership does not need to travel more than)
Behavioral Health Outpatient and Integrated Clinic, Adult*	All Except CHP	18 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	60 miles from their residence
Behavioral Health Outpatient	All*	under 18 years	Maricopa, Pima	15 minutes or 10 miles from their

and Integrated Clinic, Pediatric*				residence
			All Others	60 miles from their residence
Behavioral Health Residential Facility (BHRF)	All	All	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	(Report in Network Plan, Refer to ACOM Policy 415-Attachment B)
Cardiologist, Adult*	All except CHP	21 years or older	Maricopa, Pima	30 minutes or 20 miles

				from their residence
			All Others	75 minutes or 60 miles from their residence
Cardiologist, Pediatric*	All	Under 21 years	Maricopa, Pima	60 minutes or 45 miles from their residence
			All Others	110 minutes or 100 miles from their residence
Crisis Stabilization Facility	ACC-RBHA Only	All	Maricopa, Pima	15 minutes or 10 miles from their

				residence
			All Others	45 miles from their residence
Dentist, Pediatric	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Hospitals	All	All	Maricopa, Pima	45 minutes or 40 miles from their residence
			All Others	95 minutes

				or 85 miles from their residence
Nursing Facilities	ALTCS E/PD Only	Living in Own Home	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	95 minutes or 85 miles from their residence

Obstetrician /Gynecologist (OB/GYN)	All	15 to 45 years old	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	90 minutes

				or 75 miles from their residence
Pharmacy	All	All	Maricopa, Pima	12 minutes or 8 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Adult*	All Except CHP	21 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles

				from their residence
Primary Care Provider (PCP), Pediatrics*	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence

4. When monitoring the AdSS for compliance with Network Standards, the Division shall ensure Provider types marked with an asterisk are:
   a. Eligible for a telehealth standard modification; and
   b. Require 80 percent of a county's membership to meet these time and distance standards in any county where telehealth services are available for the Provider category.

5. The Division shall monitor Network Standards of AdSS contracts with Multi-Specialty Interdisciplinary Clinics (MSICs) in the assigned Geographic Service Area (GSA) in the state, as well as any MSICs which have provided services to the AdSS's Members.

B. NETWORK STANDARD REQUESTS FOR EXCEPTIONS FROM THE AdSS

1. The Division shall review Network Standard exception requests submitted by the AdSS and make a determination based on the following criteria:
   a. The total number of Providers in the same specialty practicing in the county;
   b. The geographic composition of the county;
   c. Provider willingness to enter into a contract;
   d. Consideration of the rates offered to non-contracted Providers to bring the AdSS into compliance with the standard;
   e. The availability of Indian Health Services 638 contract (IHS/638) facilities available to the American Indian population in the county;

f. The availability of alternative service delivery mechanisms available, such as telemedicine, Telehealth, or virtual or mobile services; and

g. The AdSS's proposal for monitoring and ensuring Member access.

2. Minimum Network Standards Reporting Requirements

a. The AdSS shall submit a completed Attachment A reporting its compliance with the applicable standards in this policy. Attachment A shall be submitted as specified in the contract. The AdSS shall report compliance with these requirements for each county in its assigned service area. A separate report shall be submitted for each line of business. For purposes of calculating and reporting this data:

i. The AdSS shall use its enrollment and its Network as of the last day of the reporting period (March 31 and September 30);

ii. The AdSS shall report the percentages in Attachment A, 'Time and Distance' tab rounded to the nearest tenth of a percent; and

iii. The AdSS shall report 'N/R' (None Reported) for each time and distance standard, instead of a percentage, where there are no Members meeting the population criteria in the county.;

iv. The AdSS shall report in Attachment A, "Time and Distance" tab, whether or not telehealth services are available in each county reported for each pProvider type eligible for a telehealth standard modification by the AdSS. This is identified by adding a 'Y' or 'N' in the "Telehealth Available (Y/N)" row underneath the Provider type; and

v. The AdSS shall consider in its dental Network any contracted FQHC identified annually by AHCCCS as providing dental services.

b. The AdSS shall analyze compliance with Network Standards based upon the Provider Network reported

through the Contractor Provider Affiliation Transmission (PAT) and available Electronic Visit Verification (EVV) data as required in AdSS Medical Policy 542. With the submission of Attachment A, the AdSS shall include a summary including, at a minimum, the following:

i. The AdSS strategies and efforts to address any areas of non-compliances;

ii. A summary of exceptions granted to the Network Standards specified in this pPolicy; and

iii. The results of the AdSS's monitoring of Member access to the services governed under the exception.

c. As specified in the contract, the AdSS shall submit a completed Attachment A including a summary analysis of any areas of non-compliance with Network Standards specified in this policy, including strategies and efforts to address areas of non-compliance.

3. Network Plan Requirements

a. The AdSS shall take steps to ensure Network Standards are maintained. If established Network Standards cannot

be met, the AdSS shall identify these gaps and address short- and long-term interventions in the Network Development and Management Plan (NDMP) as outlined in AdSS Operations Policy 415. When an exception has been granted, the AdSS shall address the sufficiency of Member access to the area and assess the continued need for the exception.

b. The AdSS shall report to the Division its Network gaps and short- and long-term interventions to address the gaps, in its NDMP as specified in AdSS Operations Policy 415.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS

REVISION DATE: 3/27/2024, 2/16/2022

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901, ACOM Policy 317, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, CMS document SMDL 09-001.

PURPOSE

This policy establishes guidelines and requirements for Administrative Services Subcontractors (AdSS) or Management Service Agreement (MSA), and monitoring subcontractor performance, reporting performance review results, and notifying AHCCCS of subcontractor non-compliance and corrective action plans (CAPs). Unless otherwise stated, requirements outlined in this policy for Administrative Services Subcontractors also apply to MSA.

DEFINITIONS

1. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Division's contract with AHCCCS, including:
    a. Claims processing, including pharmacy claims;
    b. Pharmacy Benefit Manager (PBM);

c. Dental Benefit Manager;

d. Credentialing, including those for only primary source verification;

e. Medicaid Accountable Care Organization (ACO);

f. Service Level Agreements with the Division or one of its subcontractors; and

g. CHP and DES/DDD Subcontracted Health Plan.

2. "Attachment A" means the Attachment A of the Administrative Services Subcontract Checklist. It is the AHCCCS deliverable template.

3. "Change in Organizational Structure" means any of the following:

a. Merger

b. Acquisition

c. Reorganization

d. Change in Articles of Incorporation

e. Joint Venture

f. Change in Ownership

g. Change of Management Services Agreement (MSA) Subcontractor

h. Other applicable changes that may cause:

i. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

ii. Changes in critical Member information, including the website, Provider handbook and Member ID card

iii. A change in legal entity name.

4. "Corrective Action Plan" or "CAP" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor or its Providers, to enhance Quality Management or Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

5. "Day" means a calendar day, unless otherwise specified.

6. "Management Service Agreement" or "MSA" means a type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.

7. "Medicaid Accountable Care Organization" or "ACO" means an entity that enters into a Value-Based Purchasing (VBP) arrangement with a Contractor which:
    a. Improves the health care delivery system by increasing the quality of care while reducing costs.
    b. Enters into VBP contracts with Provider groups or networks of groups.
    c. Coordinates Provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM), combined with quality incentives to ensure both quality outcomes and cost containment.
    d. Supports Providers participating in APMs by providing services such as data analytics, technical assistance, Provider education, and Provider recruitment.
    e. Operates as an intermediary between the Contractor and Providers, but not as a Provider of direct services to Members.

f. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS.

8. "Member" means the same as "client" as defined in A.R.S. § 36-551.

9. "Provider" means any person or entity that contracts with the Division or the AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a Provider delivering services pursuant to A.R.S. § 36-2901.

   a. Qualified Vendors are Providers.

   b. Providers are not Administrative Services Subcontractors.

10. "Quality of Care" or "QOC" means an expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

11. "Request for Proposal" or "RFP" means a document prepared by AHCCCS that describes the services required and that instructs a prospective Offeror how to prepare a response.

12. "Subcontractor" means:

    a. A provider of health care who agrees to furnish covered services to Members.

    b. A person, agency or organization with which the Contractor, or its subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

    c. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease or leases of real property to obtain space, supplies equipment or services provided under this Contract with the Division.

POLICY

A. APPROVAL OF SUBCONTRACTS

1. The Division shall submit an unredacted copy of all Management Service Agreements (MSA) and Administrative Services Subcontracts with the proposed Subcontract Checklist to the AHCCCS Division of HealthCare Management for prior approval, 60 days before the effective date of the subcontract.
2. The Division shall retain the authority to direct and prioritize

any delegated contract requirements.

3. The Division shall require that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS.
   a. The Division shall require that the AdSS notify a change in Organizational Structure of Administrative Services Subcontractor.
   b. The Division shall review the notification and determine if a complete Attachment A submission is required.
   c. If a complete Attachment A submission is required, the Division shall follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this policy.
4. The Division shall ensure the MSA contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of AHCCCS.
5. The Division shall ensure that any reorganization related to an MSA Subcontractor is submitted in accordance with ACOM Policy 317.
6. The Division shall:

a. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the public including any RFP amendments.

b. Submit final, signed copies of each contract that it enters into with subcontractors and any subsequent amendments within 30 days of e-signature date.

c. Ensure its subcontractors communicate with the Provider network regarding program standards, and changes in laws, policies, and contract.

d. Submit a cover letter that contains a high-level summary of the proposed changes when providing an amendment to an Administrative Services Subcontract.

B. MONITORING AND REPORTING

1. The Division shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and complete a formal review at least annually as outlined in 42 CFR 438.230.

2. In the formal review, the Division shall conduct a review of delegated duties, responsibilities, and financial position with the exception that the Division shall not conduct a financial

review of Administrative Services Subcontractors who are state agencies or sovereign nations.

a. The Division shall prepare written findings of the review.

b. The Division shall require the subcontractor to prepare a written response to findings of non-compliance.

c. The Division shall increase monitoring activities until compliance is achieved and maintained.

d. The Division shall notify AHCCCS within 30 days of the discovery of an Administrative Service Subcontractor's non-compliance with the following information:

    i. The subcontractor's name

    ii. Delegated duties and responsibilities

    iii. Identified areas of non-compliance and whether the non-compliance affects Member services or causes a quality of care concern

    iv. The scope and estimated impact of the non-compliance upon Members

    v. The known or estimated length of time that the subcontractor has been in non-compliance

vi. The Division's Corrective Action Plan (CAP) or strategies to bring the Administrative Services Subcontractor into compliance

vii. Sanction actions that may be taken because of the non-compliance

viii. The Division's activities that are occurring to bring the subcontractor into compliance.

C. ADMINISTRATIVE SERVICES SUBCONTRACTOR EVALUATION REPORT

1. The Division shall submit the annual Administrative Services Subcontractor Evaluation Report within 90 days of the start of the AHCCCS contract.
2. The Division shall ensure that the Administrative Services Subcontractor Evaluation Report includes the following:
   a. The name of the subcontractor
   b. The delegated duties and responsibilities
   c. The date of the most recent formal review of the duties, responsibilities, and financial position, as appropriate, of the subcontractor
   d. A comprehensive summary of the evaluation of the

operational and financial, as appropriate, performance of the subcontractor, including the type of review performed

e. The next scheduled formal review date

f. All identified areas of deficiency that:

   i. Affect Member services, or

   ii. Cause a quality of care concern

g. CAP Information, including:

   i. A detailed description of the reasons the subcontractor was placed on a CAP.

   ii. A description of the steps taken by the Subcontractor to address the CAP.

   iii. Date CAP reported to AHCCCS.

   iv. Current status and expected completion time of CAPs.

D. ADDITIONAL REQUIREMENTS

1. Before entering into an Administrative Services Subcontract, the Division shall evaluate the prospective Administrative Services Subcontractor's ability to perform the delegated duties.

2. The Division shall ensure that all Administrative Services

Subcontracts reference and with the Minimum Subcontract Provisions available on the AHCCCS website.

3. In the event of a modification to the AHCCCS Minimum Subcontract Provisions, the Division shall issue a notification and amend Administrative Services Subcontracts within 30 calendar days of the published change and ensure amendment of any affected subcontracts as needed.
4. The Division shall amend the affected Administrative Services Subcontracts on the regular renewal schedule or within six calendar months of the update, whichever comes first.
5. The Division shall ensure that all Administrative Services Subcontracts reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and State Medicaid Director Letter (SMDL) 09-001.
6. The Division shall ensure that the Administrative Services Subcontractors disclose to the Division and AHCCCS/Office of the Inspector General (OIG) the identity of any person excluded from the requirements outlined in subsection (5) of this section.

7. The Division shall ensure that all Administrative Services Subcontracts entered into by the Division are reviewed and approved by AHCCCS.
8. The Division shall ensure that all Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.
9. The Division shall maintain a fully executed original or electronic copy of all Administrative Services Subcontracts and make them accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.
10. The Division shall ensure that all Member communications related to the Medicaid line of business issued by the Administrative Services Subcontractor include the Division's name and comply with Member notification requirements specified in AdSS Operations Policy Manual, policy 404.
11. If the Division terminates the Administrative Services Subcontract, the Division shall ensure compliance with all aspects of the AHCCCS Contract notwithstanding the Administrative Services Subcontractor termination, including

availability of and access to all covered services and provision of covered services to Members within the required timeliness standards.

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: June 10, 2016
REFERENCES: 9 A.A.C. 22, Article 1; 42 CFR 438.207, 42 CFR 438.10(f) (4), 42 CFR 438.10(f) (5).

The Division ensures that performance and provider network standards are met to support a member's needs, as well as the needs of the membership as a whole. Changes to business operations or to the provider network are evaluated for the impact to members and providers.

Identifying A Provider Network and/or Business Operations Material Change

A. For changes impacting members and/or providers, the Division evaluates the impact of the change by geographical service area and as a whole using established criteria and/or methodology for determining the impact of the change.

B. Provider Network changes may include, but are not limited to:

1. Changes in services,
2. Geographic service areas, or
3. Payments.

C. Changes may also include the addition or change in:

1. Pharmacy Benefit Manager (PBM),
2. Dental Benefit Manager,
3. Acute Health Plan,
4. Provider Contracts (e.g. group homes, nursing facility), and
5. Any other delegated agreements.

D. Business Operations changes may include, but are not limited to:

1. Policy,
2. Process, and
3. Protocol, such as prior authorization or retrospective review.

E. Changes may also include the addition or change in:

1. Claims Processing system,

2. System changes and upgrades,

3. Member ID Card vendor,

4. Call center system,

5. Management Service Agreement (MSA), and

6. Any other Administrative Services Subcontract.

F. The Division will submit approval for a material change to AHCCCS, at least 60 days in advance of the material change.

G. Any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided will be communicated to affected providers at least 30 days in advance of the change as identified in Operations Policy Manual Chapter 60, Notification to Providers.

H. The Division will provide written notice to members within 15 days after receipt or issuance of a provider termination notice.

General Notifications

A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:

1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration.

2. For routine changes and updates to Division Guidelines, Policy/Provider Manual.

3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change.

4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.

B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.

C. Communication with Independent Providers is via US mail.

D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.

446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

REVISION DATE: 10/1/2021, 12/04/2019
EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Contractor Operations Manual (ACOM), Policy 446

This Policy applies to the Division of Developmental Disabilities and their subcontractors and outlines procedures related to grievances and investigations conducted by AHCCCS and the subcontractors under A.A.C. R9-21-402 et seq. concerning persons with a Serious Mental Illness (SMI).

A. This Policy applies to grievances or requests for investigation asserted by, or on behalf of, persons designated with a SMI to the extent the allegation asserts a violation relating to the right to receive services, supports and/or treatment that are state-funded and are no longer funded by the state.

   1. For persons designated as SMI, AHCCCS, the Division, and its subcontractor conduct investigations into allegations of physical abuse, sexual abuse, violations of SMI rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a member's death that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

      a. Refer to *AHCCCS Contractor Operations Manual, Chapter 400-Operations, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness* for full details and requirements of such grievance investigations.

   2. AHCCCS, or the Contractor before whom a grievance or request for investigation is pending, must immediately take whatever action may be reasonable to protect the health, safety, and security of any member, complainant, or witness.

B. Grievances involving an alleged rights violation, or a request for investigation involving an allegation where a condition requiring investigation exists, which occurred in an agency operated by a Division Subcontractor or one of its subcontracted providers and which does not involve a member's death or an allegation of physical or sexual abuse, must be filed with and investigated by the subcontractor.

C. The DDD Customer Service Center must refer any grievances or requests for investigation related to physical or sexual abuse or death to AHCCCS to begin the investigative process.

D. Support Coordinators must complete *DDD-2044A FORENG (11-19) Serious Mental Illness Grievance and Appeal Form* and send the form to DDD Customer Service Center (CSC) for the Division's internal use when a member with an SMI designation wants to file a grievance or appeal. This serves as the Division's notice of the grievance and appeal. The notice will allow the Division to effectively monitor the grievance or appeal and ensure it is resolved by the proper entity and within the

required timeframe.

E. Once notified, CSC will open a grievance in the Resolution System (RS) for violations related to member's rights.

1. The grievance procedure must follow the same procedure as other CSC grievances.

2. The purpose of this grievance policy is to ensure the subcontractor is investigating the matter properly and in a timely fashion, pursuant to the clauses outlined in the *AHCCCS Operations Manual, Chapter 400, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness.*

F. A grievant or the DDD member who is the subject of the grievance, who disagrees with the final decision of the subcontractor may file a request for an administrative appeal with AHCCCS within 30 days from the date of their receipt of the subcontractor's decision. The request for administrative appeal must specify the basis for disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the subcontractor decision.

G. When an administrative appeal is filed, the subcontractor must forward the full investigation case record, which includes all elements described in A.A.C. R9-21-409(D)(1), to AHCCCS. The failure of the subcontractor to forward a full investigation case record that supports the subcontractor's decision may result in a summary determination against the subcontractor. The subcontractor must prepare and send with the investigation case record, a memo which states:

1. Any objections the subcontractor has to the timeliness of the administrative appeal,

2. The subcontractor's response to any information provided in the administrative appeal that was not addressed in the investigation report, and

3. The subcontractor's understanding of the basis for the administrative appeal.

H. If an extension of any time frame related to the grievance process is needed, it must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:

1. The subcontractor investigator or any other subcontractor official responsible for responding to grievances must address the extension request to the subcontractor Director or designee.

2. The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address the extension request to the AHCCCS Deputy Director or designee.

3. A subcontractor request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance must be addressed to the AHCCCS Deputy Director or designee.

4. Requests for extension must be in writing, with copies to all parties.

5. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the member.

6. The request must explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.

7. Such request must be submitted to and acted upon prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed constitutes a denial of the request for an extension.

I. Within 15 days of receipt of a timely filed administrative appeal, AHCCCS must review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and must prepare a written, dated decision.

1. A grievant or person who is the subject of the grievance who is dissatisfied with a decision of AHCCCS may request an administrative hearing before an administrative law judge within 30 days of the date of receipt of the decision.

II. DDD Tribal Health Program (THP) who serve members that are diagnosed with an SMI diagnosis will follow the same grievance process as outlined above.

III. In addition to a grievance or request for investigation which may be filed pursuant to this Policy and A.A.C. Title 9, Chapter 21, Article 4, a separate investigation into the death of a person receiving services must be conducted as described in AMPM Policy 960.

IV. Grievance Investigation Records: AHCCCS and the subcontractor will maintain records in the following manner:

1. All documentation received related to the grievance and investigation process will be date stamped on the day received.

2. A complete grievance investigation case record must be maintained for each case.

3. Copies of all information generated or obtained during the investigation.

4. All grievance and investigation files in a secure designated area and retain for at least five years.

5. A public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

6. Confidentiality and privacy of grievance and investigations records.

7. The complete grievance investigation case must include:

a. The original grievance/investigation request letter and the AHCCCS Appeal or SMI Grievance Form, and

b. Copies of all information generated or obtained during the

investigation.

8. The investigator's report that includes:

   a. A description of the grievance issue,

   b. Documentation of the investigative process,

   c. Names of all persons interviewed,

   d. Written documentation of the interviews,

   e. Summary of all documents reviewed,

   f. The investigator's findings.

   g. Conclusions and recommendations.

   h. A copy of:

      i. The acknowledgment letter,

      ii. Final decision letter,

      iii. Corrective action documentation, and

      iv. Any information/documentation generated by an appeal of the grievance decision.

449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

REVISION DATE: 6/29/2022

EFFECTIVE DATE: November 29, 2018

REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division). The purpose of this policy is to ensure the timely provision of behavioral health services to children eligible for Title XIX services who are residing with an out-of-home caregiver or children in out-of-home dependency with the Department of Child Safety (DCS), as specified throughout this policy, and to adopted children in accordance with A.R.S. § 8-512.01.

This policy delineates the Division's roles and responsibilities with respect to oversight of the Administrative Services Subcontractors (AdSS) and the Division's role with respect to support coordination.

DEFINITIONS

Adoptive Parent means any adult who is a resident of Arizona, whether married, unmarried, divorced or legally separated, who has adopted a child. For purposes of this policy, the adoptive parent is that of a child who is eligible under Title XIX of the Social Security Act.

Arizona Department of Child Safety (DCS) means the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.

2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.

3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.

4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Behavioral Health Out-of-Home Treatment means highly individualized treatment services and support interventions to meet the needs of each child and their family. When community-based services are not effective in maintaining the child in his/her home setting, or safety concerns become critical, the use of out-of-home treatment services can provide essential behavioral health interventions to stabilize the situation. The primary goal of out-of-home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to his/her home and community settings.

Crisis means an acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

Crisis Services means services that are community based, recovery-oriented, and member focused that work to stabilize members as quickly as possible to assist them in returning to their baseline of functioning.

Member for purposes of this policy includes children residing with out-of-home caregivers, children in out-of-home dependency with DCS, and adopted children.

Out-of-Home Caregiver for purposes of this policy is where a child in DCS custody resides (i.e., kinship care, foster care, a shelter care provider, a receiving home, independent living program or group foster home).

Rapid Response is a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health needs and to refer the child for additional assessments through the behavioral health system.

POLICY

The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy, and whose contract includes this requirement. The Division remains responsible for support coordination and oversight of the AdSS. (Refer to AdSS Operations Policy 449 for AdSS responsibilities.) The Division shall ensure timely provision of all behavioral health services for members enrolled with the AdSS. The Division shall ensure the AdSS provide coordinated care between the out-of-home caregiver or adoptive parent(s), all providers, and DCS, as appropriate.

A. GENERAL REQUIREMENTS

1. To meet the needs of members residing with an out-of-home caregiver, children in out-of-home dependency with DCS, and

adopted children, the Division shall:

a. Ensure services delivered through the AdSS are provided as specified in AdSS Operations Policy 417, and

b. Ensure the AdSS has availability of a telephone line, with designated staff, adequately trained on the provisions of this policy and the procedures in place to address calls.

B. REQUEST FOR BEHAVIORAL HEALTH OUT-OF-HOME TREATMENT

The Division shall ensure AdSS compliance with the following:

1. After a request is made to place a member in behavioral health out-of-home treatment, the AdSS shall issue a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include, but are not limited to, Behavioral Health Facilities as specified in A.A.C R9-10-101. If the AdSS determines there is insufficient information to make a determination, the AdSS shall document all substantive efforts to obtain required information within the 72-hour timeframe. If the request for behavioral health out-of-home treatment is denied, the AdSS shall ensure medically necessary alternative services are provided. BHRF denials by the AdSS shall be sent to the Division Utilization Management Unit for secondary review by the Division's Behavioral Health Medical Director. The Behavioral Health Medical Director shall review and may approve or overturn the denial from the AdSS.

2. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment, the AdSS shall coordinate with the hospital, Support Coordinator and Child and Family Team (CFT) to ensure an appropriate and safe discharge plan. The discharge plan shall include recommended follow-up services, including recommendations made by the CFT. For additional requirements regarding discharge planning refer to AMPM 1020.

3. The AdSS shall collaborate with DCS and the Support Coordinator to ensure an appropriate alternative for the member to be discharged when

   a. It is unsafe for the member to return to the out-of-home caregiver or adoptive parent(s), and/or

   b. It is unsafe for the out-of-home caregiver or adoptive parent(s) for the member to return.

4. The AdSS shall issue a Notice of Adverse Benefit Determination (NOA) as specified in AdSS Operations Policy 414 for any adverse action related to the request for any adverse action related to the request for behavioral health out-of-home treatment.

5. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria were not met but there was not a safe discharge plan in effect to meet the needs and safety of the member and the out-of-home caregiver or adoptive parents. In

these cases, the AdSS is responsible for payment regardless of principal diagnosis on the claim and may negotiate with the hospital for an appropriate rate.

C. BEHAVIORAL HEALTH APPOINTMENT STANDARD

The Division shall ensure AdSS compliance with the following:

1. Upon notification from an out-of-home caregiver or adoptive parent that a recommended behavioral health service is not provided to a member (as specified in AdSS Operations Policy 417), the AdSS shall:

    a. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to the Health Plan Customer Service (Mercy Care 800-624-3879 and United Healthcare 800-348-4058), as applicable;

    b. Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the AdSS;

    c. Obtain the name and contact information of the identified non-contracted provider of service, if applicable, to verify their AHCCCS registration; and

    d. Obtain information needed to determine medical necessity of requested services not received.

2. For services provided by a non-contracted provider, the AdSS shall:

a. Not deny claims submitted based solely on the billing provider being out of network, and

b. Reimburse clean claims at the lesser of 130% of the AHCCCS Fee-For-Service Rate or the provider's standard rate and as specified in AdSS Operations Policy 203.

c. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

D. EDUCATION

The Division shall ensure AdSS compliance with the following:

1. The AdSS is responsible for providing education to providers, Primary Care Physicians, members, families, CFT members and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to the following areas:

   a. Rights and responsibilities as delineated in A.R.S. §8-512.01,

   b. Trauma-informed care,

   c. Navigating the behavioral health system,

   d. Coordination of care as specified in this policy,

   e. Covered services,

   f. Referral process including Arizona Families First (Family in Recovery Succeeding Together; AFF),

g. The role of the AdSS,

h. The role of DCS as applicable, and

i. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

2. The AdSS shall provide training and education to primary care providers regarding the behavioral health referral process.

3. All AdSS member information shall meet the requirements of AdSS Operations Policy 404.

4. The Division reserves the right to verify education programs when performing oversight of the AdSS. AHCCCS reserves the right to verify education programs when performing a review of the Division.

E. REQUIREMENTS FOR CHILDREN IN THE CUSTODY OF DCS

In addition to the requirements above, the Division shall ensure the AdSS meets the requirements included in this section:

1. Telephone Line

a. Ensure the availability of a telephone line, with designated staff, that is responsible for handling incoming calls after business hours related to delivery of services, including failure of an assessment team to respond within two hours, and

b. Designated staff shall be adequately trained on the

provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There shall be processes in place for staff to:

i. Address barriers to care,

ii. Directly contact the crisis services vendor and/or provider,

iii. Track and report calls as specified throughout Policy, and

iv. Report the above information to the Children Services Liaison.

2. Continuity of Services

a. The AdSS is responsible for continuation and coordination of services the member is currently receiving.

b. If the member moves into a different county because of the location of the out-of-home caregiver, the AdSS must allow the member to continue any current treatment in the previous county and/or seek any new or additional treatment in the current county of residence regardless of the AdSS provider network.

3. Children Services Liaison

a. The AdSS shall designate an individual whose role is to serve as the member's single point of contact for accepting and responding to:

i. Inquiries from the out-of-home caregiver, adoptive parent, or providers,

ii. Issues and concerns related to the delivery of and access to behavioral health services for members,

iii. Collaborate with the out-of-home caregiver and adoptive parents to address barriers to services, including nonresponsive crisis providers, and

iv. Resolve concerns received in accordance with grievance system requirements.

b. The Children Services Liaison shall:

i. Provide the number for crisis services and after-hours telephone line in their outgoing voicemail message and email;

ii. Provide an expected timeframe for return calls in their outgoing voicemail message and email;

iii. Respond to all inquiries as indicated by need or safety but no later than one business day; and

iv. Follow up on all calls received by the after-hours telephone line.

c. The Division shall ensure the AdSS Children Services Liaison contact information is:

i. Provided to AHCCCS and DCS for distribution,

ii. Prominently placed on the member page of the AdSS' website, and

iii. Included in the Member Handbook.

d. The AdSS shall ensure calls received by the Children Services Liaison that meets the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

F. TRACKING AND REPORTING

1. The Division shall conduct ongoing oversight of the AdSS through a review of the following reporting to ensure compliance with this policy:

   a. Monitor, as specified in the AHCCCS Contract, an Access to Services Report using Attachment A to ACOM 449.

   b. Monitor and submit, as specified in the AHCCCS Contract, the number of calls and emails received by the AdSS Children Services Liaisons and the after-hours line related to children residing with out-of-home caregiver or children in out-of-home dependency with DCS specific to this policy (Attachment B to ACOM 449), and

   c. Monitor and submit, as specified in the AHCCCS Contract, a Rapid Response Reconciliation reporting all Rapid Response information for children in DCS custody (Attachment B). The Division shall ensure the AdSS perform a reconciliation of members placed in DCS custody

in contrast to those who have received a Rapid Response service. For any identified members in DCS custody who have not been engaged in behavioral health services, the AdSS shall ensure a Rapid Response service is delivered. For any identified members in DCS custody who are already receiving or otherwise are engaged in behavioral health services, the AdSS shall ensure an assigned service provider contacts the member and caregiver to conduct an assessment of the current status.

G. DIVISION OVERSIGHT OF AdSS:

The Division shall conduct oversight activities including, but not limited to the following methods to ensure compliance with this policy and policies referenced within this policy:

1. Annual Operational Review of related standards, including but not limited to:
    a. AdSS has policies and procedures in place and demonstrates compliance with them to ensure members in foster care receive behavioral health services in alignment with this policy and AdSS 417.
    b. AdSS demonstrates compliance with the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.
    c. AdSS provides evidence of training and education provided to primary care providers regarding the

behavioral health referral process.

d. AdSS monitors for evidence in the medical record and the member's individual service plan that medically necessary services were determined by a qualified behavioral health professional.

2. Receive and review deliverable reports to ensure compliance and address service gaps or non-compliance. Submit collated data received from the AdSS and submit reports as required by contract to AHCCCS.

3. Conduct a cadence of oversight meetings with each AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

1001-A RIGHTS AND RESPONSIBILITIES OF INDIVIDUALS SUPPORTED BY THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATE: 1/3/2024, 4/21/2023, 7/3/2015

REVIEW DATE: 6/23/2023

EFFECTIVE DATE: July 13, 1993

REFERENCES: A.R.S. § 36-551.01, A.R.S. § 41-3801, A.R.S. § 41-1492 et seq., A.R.S. § 41-1959; A.A.C. R9-21-211; A.A.C. R6-6-102; R6-6-104, R6-6-107, R6-6-108, R6-6-804, R6-6-901, R6-6-901-910 et seq., R6-6-1801 et seq., R6-6-1114

PURPOSE

To identify the rights and responsibilities that an individual has by virtue of being enrolled in programs operated or overseen by the Division of Developmental Disabilities (Division or DDD).

DEFINITIONS

1. "Individualized Family Service Plan" or "IFSP" means a written plan for providing early intervention services to an infant or toddler with a disability and the child's family that (a) is based on the evaluation and assessment; (b) includes parental

consent; c) is implemented as soon as possible once parental consent is obtained; and (d) is developed in accordance with IDEA Part C.

2. "Person-Centered Service Plan" or "PCSP" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important

to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. MEMBER RIGHTS

1. The Division shall recognize that an individual with a developmental disability has the same rights, benefits, and privileges guaranteed by the constitutions and laws of the United States and the State of Arizona, including the:

   a. Right to exercise their rights as a citizen;

   b. Right to participate in social, religious, educational, cultural, and community activities;

   c. Right to own, rent, or lease property;

   d. Right to marry and have children;

   e. Right to be free from involuntary sterilization;

f. Right to express human sexuality and receive training as appropriate;

g. Right to consume alcoholic beverages if 21 years of age or older unless contraindicated by orders of their primary care provider or the court;

h. Right to the presumption of legal competency in guardianship proceedings;

i. Right to own and have free access to personal property;

j. Right to associate with persons of their own choosing;

k. Right to manage personal financial affairs and to be taught to do so;

l. Right to the least amount of physical assistance necessary to accomplish a task;

2. The Division shall recognize the following additional rights of an individual with a developmental disability receiving supports and services through the Division:

a. Right to be treated fairly regardless of race, ethnicity, culture, national origin, ancestry, religion, gender identity or expression, age, health, social origin or condition, creed, behavioral condition (intellectual) or physical disability, sexual orientation, genetic information, marital status, medical condition, or ability to pay;

b. Right to be treated with respect and with due consideration for their dignity and privacy by DDD staff and providers;

c. Right to a safe, clean, and humane physical environment;

d. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

e. Right to protection from physical, verbal, sexual, psychological, or financial abuse, punishment, neglect, or exploitation;

f. Right to be free from overcorrection or the application of noxious stimuli as a negative consequence of a behavior;

g. Right to know who their Support Coordinator is and how to request a new Support Coordinator;

h. Right to an initial Person Centered Service Plan or Individualized Family Services Plan (PCSP or IFSP) planning document prior to receiving supports and services;

i. Right to participate and share in decision-making once approved and to receive a written PCSP or IFSP based upon relevant assessment results;

j. Right to participate in the PCSP or lFSP, periodic evaluations, and whenever possible, the opportunity to select among appropriate alternative supports and services;

k. Right to a periodic review of the PCSP or IFSP planning document;

l. Right to be supported by the organization to collaborate on decisions with their case manager;

m. Right to be informed of all case management services available, even if a service is not covered, and to discuss options with their case manager;

n. Right to be provided choices and to express individual preferences that will be respected and accepted;

o. Right to be given information in a way they can understand;

p. Right to have interpreter services or documents translated into their primary language;

q. Right to be given written notice of their rights in their primary language, in a manner that can be easily understood in the primary mode of communication, if possible;

r. Right to live in the least restrictive setting. A least restrictive setting refers to an environment in which a member strives to reach their full potential in accordance to the tenets of self-determination;

s. Right to equal employment opportunities based on the member's ability to meet qualifications;

t. Right to fair compensation for labor;

u. Right to be free from unnecessary and excessive medication. Medication shall not be used as punishment, for the convenience of the staff, as a substitute for a PCSP or IFSP, or in quantities that interfere with the member's PCSP or IFSP;

v. Right to be accorded privacy when receiving mail, during visits and telephone conversations;

w. Right to be accorded privacy during personal care, medical treatments, or personal discussions;

x. Right to confidentiality of information and medical records;

i. Have personally identifiable data and medical information kept confidential;

ii. Know what entities have access to their information;

iii. Know procedures used by DDD to ensure their security, privacy and confidentiality.

z. Right of a school-age member to receive publicly-supported educational services;

aa. Right of a child to receive appropriate supports and services, subject to available appropriations, which do not require the relinquishment or restriction of parental rights or custody, except as prescribed in A.R.S. § 8-533, which describes the grounds needed to justify the termination of the parent-child relationship;

bb. Right to withdraw from programs, supports and services, unless the member was assigned to the Department of Child Safety by the juvenile court or placed in a secure facility by the guardian and court;

cc. Right to file a grievance against the Division.

dd. Get help understanding the appeal process including how to appeal when a benefit is denied;

ee. Right to access information about the Division, its staff, its contractors, and staff qualifications.

ff. Right to refuse interviews related to crimes committed against them;

gg. Right to consent to or withhold consent from participation in a research project approved by the Division management team or any other research project: right to knowledge regarding the nature of the research, potential effects of a treatment procedure as part of a research project, right to confidentiality, and the right to withdraw from the research project at any time.

hh. Right to petition the Superior Court for redress when they believe that their rights have been violated, unless other remedies exist under federal or State laws;

ii. Right to contact the Independent Oversight Committee;

3. The Division shall recognize the following additional rights of an individual with a developmental disability who is eligible for the Arizona Long Term Care System (ALTCS):

   a. Right to know about providers who speak languages other than English;

   b. Right to receive services in the community at the same level as others not receiving Medicaid home and community based services;

   c. Right to select where services are provided based on individual needs, preferences and resources;

   d. Right to make life choices, including daily activities, physical environment, with whom they interact, and who provides services and supports;

   e. Right to have personal care needs provided, except for cases of emergency, by a direct care staff of the gender chosen by the responsible person; this choice shall be specified in the Planning Document;

f. Right to make decisions about their care, including refusing care or getting details about what could happen if they do or do not get care;

g. Right to get a second opinion from a qualified physical or behavioral health care professional at no cost within their health plan network or outside the network if there is no in-network option;

h. Right to get information about their treatment options and alternatives in a way that is understandable;

i. Right to develop a contingency plan with their provider agency to decide what they want to do if a caregiver is late or does not show up for each of their assessed services;

j. Right to request information about the structure and operation of their health plan, including their contract with the Division of Developmental Disabilities;

k. Right to know how their health plan pays providers, controls costs, and uses services;

l. Right to see their health care records at any time and to request they be changed or corrected;

m. Right to request a copy of their health care records at no cost every year and to receive a response to that request within 30 days of making the request;

n. Right to receive emergency care at any hospital or other setting without prior approval from their doctor or health plan;

o. Right to create advance directives that protect their right to refuse unwanted health care or to request wanted care if they are too ill to make decisions;

p. Right to file a grievance not only with the Division but also with their health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);

q. Right to get information on beneficiary and plan information;

r. Right to information regarding the supports and services available through a provider and about related charges, including any fees for supports and services not covered by a third-party payor;

s. Right to an administrative review, if in disagreement with a decision made by the Division, by filing a verbal or written request for such with the DDD Office of Compliance and Review, and the right to appeal the decision;

4. The Division shall recognize the following additional rights of an individual with a Serious Mental Illness designation:

a. Right to receive the right kind of mental health services based on individual need;

b. Right to Participate in all areas of mental health treatment, including individual service or treatment plan meetings;

c. Right to have a discharge plan before leaving the hospital;

d. Right to consent or say Yes or No to treatment (except in an emergency or by court order);

e. Right to have treatment or medical help in a similar area as others or in the least restrictive area to meet the individual needs;

f. Right to be free from unnecessary seclusion or restraint;

g. Right to not be physically, sexually, or verbally abused;

h. Right to privacy (mail, visits, telephone conversations);

i. Right to file an appeal or grievance when unhappy with services, something is not working, or feel treated unfairly;

j. Right to choose a designated representative(s) to assist during service or treatment planning meetings and in filing grievances;

k. Right to a case manager to work with you to get the services or help needed;

l. Right to a written behavioral health service or treatment plan that sets forth the services you will receive;

m. Right to associate with others;

n. Right to confidentiality of psychiatric records;

o. Right to get copies of psychiatric records (unless it would not be in the best interest to have them);

p. Right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days; and

q. Right to not be discriminated against in employment or housing.

5. The Division shall recognize the following additional rights of individuals living in Community Residential Settings:

a. Right to be treated with dignity and respect by DDD staff and providers;

b. Right to impartial access to treatment or accommodations;

c. Right to a safe, humane, and clean physical environment;

d. Right to make decisions about their care, including refusing care or getting details about what could happen if they do

or do not get care and communicate directly with those responsible to provide care;

e. Right to choose their personal care provider;

f. Right to be informed of their medical condition, of any technical procedures which may be performed, of the identity of the persons who will perform the procedures, attendant risks of treatment and the right to refuse treatment;

g. Right to be free from unnecessary drugs and physical restraints, except as authorized in writing by a physician for a specified time period and in accordance with the Division rules regarding behavior supports;

h. Right to a physical examination and prompt medical attention;

i. Right to refuse to talk with or see someone;

j. Right to participate in social, religious, and community group activities;

k. Right to manage their own financial affairs and be taught to do so to the extent of their capabilities;

l. Right to refuse to perform services for the home, but if they do provide services, right to be compensated at prevailing wages commensurate within state and federal laws and as prescribed by the Industrial Commission;

m. Right to file an incident report;

n. Right to file a grievance not only with the Division but also with their health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);

o. Right to the least amount of physical assistance necessary to accomplish a task;

p. Right to have care for personal needs provided, except in cases of emergency, by a direct care staff of the gender chosen by the responsible person and to have the choice specified in the PCSP or IFSP planning document;

q. Right to use available resources to select the home in the community in which they live;

r. Right to have a written residency agreement in place;

s. Right to have keys to their home and bedroom doors, or alternatives in place, to support the free entry and exit from their home;

t. Right to physically access their home and areas within their home;

u. Right to have choices over whom they live with, and only share a bedroom if they choose to do so;

v. Right to decide how to furnish and decorate their home;

w. Right to decide how to use outdoor spaces;

x. Right to have access to privacy within their homes including privacy with regard to written correspondence, telephone communication, and visitors;

y. Right to make informed choices about how they spend their time in and outside of their homes;

z. Right to have access to food and supplies within their home;

aa. Right to have visitors when they want to;

bb. Right to own and have free access to personal property.

B. MEMBER RESPONSIBILITIES

1. The Division shall notify all individuals supported by the Division of Developmental Disabilities that they have the responsibility to:

   a. Be as active a participant as possible in their person-centered service plan (PCSP) meetings;

   b. Notify their Support Coordinator in advance if they are unable to attend their scheduled person-centered service planning meetings;

c. Follow the mutually agreed-on person-centered service plan or notify their Support Coordinator if they cannot follow the plan;

d. Notify their Support Coordinator and their usual care provider(s) if they disenroll from DDD;

e. Provide DDD with accurate and timely information necessary to deliver services;

f. Participate in the DDD redetermination process at ages 6 and 18 or at any time deemed appropriate by the Division's Assistant Director.

2. The Division shall notify all individuals supported by the Division of Developmental Disabilities who are also eligible for the Arizona Long Term Care System (ALTCS) that they have the responsibility to:

a. Participate in the Arizona Long Term Care System (ALTCS) eligibility process, including providing documentation when requested;

b. Keep scheduled doctors and therapy appointments or cancel them at least 24 hours ahead of time;

c. Go to your doctor during office hours if possible instead of using urgent care or the emergency room;

d. Provide accurate and honest information to health care providers;

e. Notify the Division of changes in private/commercial health insurance coverage, including Medicare or Tricare, or other qualifying life event;

f. Follow instructions provided by health care providers and ask questions if they do not understand the instructions.

1001-B RESPONSIBILITIES OF INDIVIDUALS APPLYING FOR AND/OR RECEIVING SUPPORTS AND SERVICES

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

Applying for and/or receiving supports and services individuals with developmental disabilities are to be supported in exercising the same rights and choices and afforded the same opportunities enjoyed by other citizens. The Division provides this support by following the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life shall be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, preferences, strengths and needs. For individuals receiving services through the Division, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support. The Division offers many options for a member wanting to make more choices about services and supports, such as:

A. Selecting a Support Coordinator;

B. Selecting and directing their planning process, either an Individual Support Plan and/or a Person-Centered Plan;

C. Selecting service providers, both qualified vendors and individual independent providers;

D. Hiring, managing, and firing service providers;

E. Using a fiscal intermediary to manage the financial aspects of having a service provider who is his/her employee; and,

F. Having the spouse serve as his/her provider.

1002 VOTER REGISTRATION

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

All support coordination staff must comply with the Arizona Department of Economic Security Policy DES 1-01-24, regarding the National Voter Registration Act of 1993, and applicable state statutes, by offering individuals applying for services the opportunity to register to vote.

Staff will accept the verification of U.S. Citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. Citizenship document.

Staff will sign the acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by new employees within 60 days of hire. The signed copy is maintained in the Supervisor's file.

1003 DISTRICT INDEPENDENT OVERSIGHT COMMITTEES

REVISION DATE: 01/18/2023, 07/10/19, 07/13/15

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 41-3801; A.R.S. § 41-3804

PURPOSE

This policy outlines duties and membership body requirements for Independent Oversight Committees, which are established to promote rights of clients who are receiving developmental disabilities services.

POLICY

A. INDEPENDENT OVERSIGHT COMMITTEE DUTIES

The Division of Developmental Disabilities (Division) shall establish Independent Oversight Committees within specific Division districts**:** Central, East, North, West, and South. Each Independent Oversight Committee shall:

1. Meet at least quarterly each calendar year, or as often as necessary as determined by the chairperson, in accordance with the bylaws of the committee.
2. Provide independent oversight to ensure the rights of members are protected, including but not limited to:

a. Incidents of possible abuse, neglect, or denial of an individual's rights.

b. Administration of medication that changes recipient's behavior directly or as a side effect.

c. Aversive or intrusive programs.

d. Research proposals in the field of developmental disabilities that directly involve individuals receiving supports and services.

3. Submit, in writing, to the Arizona Department of Administration (ADOA) Director, any objections it has to specific concerns, actions by employees of the Division, or actions by employees of service providers.

4. Issue an annual report summarizing its activities and making recommendations of changes it believes the Division should consider implementing.

5. Additional information for specific DDD Independent Oversight Committees are available on the DDD ADOA website.

B. INDEPENDENT OVERSIGHT COMMITTEE MEMBERSHIP

1. Each committee shall be comprised of at least seven and not more than15 persons with expertise in one or more of the following areas:
    a. Psychology
    b. Law
    c. Medicine
    d. Education
    e. Special education
    f. Social Work
    g. Criminal Justice
2. Each committee shall include at least two parents of developmentally disabled members who receive services from the Division.
3. Employees of the Department of Economic Security, and subject-matter experts may serve on a committee only as non voting members whose presence is not counted for the purpose of determining a quorum
4. When there is a vacancy in an existing committee's membership, the committee shall review nominees presented by advocacy

groups, local advisory councils, committee members, and the ADOA director.

1004-A INFORMED CONSENT

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-551 (15) and 36-561.

As one means of protecting the rights of consumers, the Division requires written consent from the individual/responsible person for release of confidential information. Consents may also be required for participation in events, medical treatments, and activities. A.R.S. § 36-551 (15) defines consent as voluntary informed consent. Consent is voluntary if not given as the result of coercion or undue influence.

Consent is informed if the person giving the consent has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of the alternatives to the procedure; and, has been informed and comprehends that withholding or withdrawal of consent will not prejudice the future provision of care and supports and services to the individual. In case of unusual or hazardous treatment procedures performed pursuant to A.R.S. § 36-561, subsection A, experimental research, organ transplantation and non-therapeutic surgery, consent is informed if, in addition to the foregoing, the individual/responsible person giving the consent has been informed of and comprehends the method to be used in the proposed procedure.

All consents must be time or event-limited. Consent may be withdrawn at any time by giving written notification to the individual's Support Coordinator.

Consumer's Competency Questioned

When a consumer's ability to make decisions about medical treatment/ procedures is questioned, the matter must be forwarded to the Division's Medical Director for consideration.

1005-A GUARDIANSHIP AND CONSERVATORSHIP OR SURROGATE PARENT

REVISION DATE: 9/30/2016, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 15-761, 15-763, et seq.; 36-551 (01)(H), 36-551(17), 36-564(D), 14.5101, et seq.; 14-5105, 14-5311, 14-5303-5304, 14-5310; 14-5401, 14-5312; 14-5408(C); 14-5315; A.A.C. R6-6-1401. Public Law 105-17.

REFERENCES: A.R.S. §§

Guardianship is a legal method that is used to insure that a person who is unable to make reasoned decisions has someone specifically assigned to make decisions on his/her behalf. A guardian must be appointed by a court. A conservator refers to a person appointed by a court to manage the estate of a protected person. A person may have a guardian, a conservator or both appointed by the court.

Guardianship or conservatorship for persons with developmental disabilities shall be:

A. Utilized only as is necessary to promote the well-being of the individual;

B. Designed to encourage the development of maximum self- reliance and independence in the individual; and,

C. Ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations.

Appointment of a Guardian or Conservator

Only a court can determine that someone needs a guardian. Neither the family nor a Support Coordinator can unilaterally or jointly make that determination. However, the individual himself/herself, a family member, or any person interested in his/her welfare may petition the court (file a request for a hearing in a State court) for a finding of incapacity and the consequent appointment of a guardian. The court will appoint an attorney to represent the allegedly incapacitated person in the hearing unless the individual has his/her own attorney.

It should be noted that under Arizona law, a person with a developmental disability is presumed legally competent in guardianship proceedings until the court makes a determination to the contrary.

The person alleged to be incapacitated shall be interviewed by a person appointed by the court (called a court visitor) and examined by a court appointed physician, psychologist, or a registered nurse who will submit written reports to the court. In addition, the court visitor shall interview the person seeking appointment as guardian, and visit the home of both the individual and the proposed guardian.

During the hearing, the individual who is the subject of the hearing, has the right to be represented by an attorney, to be present at the hearing, to see or hear all evidence, to present evidence, to cross-examine witnesses, and to trial by jury. If the individual alleged to be incapacitated or his/her counsel requests, the issue may be determined at a closed

hearing.

Before a guardian can be appointed, the court must be satisfied "by clear and convincing evidence" that the appointment of a guardian or conservator is necessary to provide for the demonstrated needs of the individual.

In case of an emergency situation, the court can appoint a temporary guardian and/or a temporary conservator.

If the appointment of a guardian or conservator is required for a American Indian who is a member of an Indian Tribe and who has significant contacts with that tribe, but who is not an Indian child within the scope of federal law, the Arizona Administrative Code requires that the appointment of a guardian or conservator shall first be requested through the appropriate tribal court, if any, unless the request through the tribal court is not in the recipient's best interests as determined by the Individual Support Plan (ISP) team.

Who May be Guardian

Any competent person may be appointed guardian by the Court. Persons who are not disqualified have priority for appointment as guardian in the following order:

A. Spouse;

B. Individual or corporation nominated by the person, if in the opinion of the court, the person has sufficient mental capacity to make an intelligent choice for guardian;

C. An adult child;

D. A parent, including a person nominated by will or other writing signed by a deceased parent;

E. A relative with whom the individual has resided for more than six months prior to the filing of the petition;

F. The nominee of a person who is caring for the person or paying benefits to him/her; or,

G. A public or private fiduciary, professional guardian, conservator.

The court may give preference for the appointment of a family member unless this is contrary to the expressed wishes of the individual or is not in his/her best interest as determined by the court.
Persons who wish to be considered for appointment as a temporary or permanent guardian or conservator must provide the court with all required information. Specifically, the proposed guardian must disclose any interest in any enterprise providing health care or comfort care services to any individual.

Duties of a Guardian

A guardian's duties include, but are not limited to:

A. Encouraging the individual to develop maximum self-reliance and independence;

B. Working toward limiting or terminating the guardianship and seeking alternatives to guardianship;

C. Finding the most appropriate and least restrictive setting for the individual consistent with his/her needs, capabilities and financial ability;

D. Making reasonable efforts to secure medical, psychological, and social services for the individual;

E. Making reasonable efforts to secure appropriate training, education, and social and vocational opportunities for the individual;

F. Taking care of his/her ward's clothing, furniture, vehicles, and other personal effects;

G. Giving consents or approvals for medical or other professional care that may be necessary; and,

H. Completing all reports required by the court.

To encourage the self-reliance and independence of the individual (the ward), the court may grant him/her the right to handle part of his/her money or property without the consent or supervision of a conservator. This may include allowing the individual to maintain appropriate accounts in a bank or other financial institution.

Procedures

As part of the annual review, the ISP team shall evaluate the possible need for a guardian and/or conservator for an individual receiving services through DES/DDD. This information must be noted on the ISP form DD-217 - 2 (Team Assessment Summary, cont) under guardianship status.

When there is serious doubt regarding the ability of the individual applying for services or receiving services to make or communicate responsible decisions, every effort must be made to have a judicial determination made regarding the need for guardianship and/or conservatorship.

In the case of minor child where there is no parent or interested party who is willing and able to serve as guardian, the Support Coordinator should refer the child to Department of Child Safety (DCS).

If an individual is 18 years of age or older, the parents are not the guardians unless they have been so appointed by the court. Thus, parents cannot continue to sign medical consent forms, etc. for their children who have become of legal age. The parents may wish to pursue guardianship status.

If the Support Coordinator and/or the ISP team believes that a determination of legal competency should be pursued, the Support Coordinator should:

A. Explain the need to the individual and/or family;

B. Work with the individual/and or family to help them understand the process necessary for obtaining a guardian and/or a conservator;

C. Refer the individual and/or family for help, if it is needed, in securing an attorney to handle the proceedings; (referrals, for example, to: Arizona Center for Law in the Public Interest, Community Legal Services, The Arc);

D. If the individual/family is unwilling or unable to seek guardianship, the Support Coordinator must pursue guardianship by:

1. Writing a letter to the county public fiduciary where the individual receives services explaining the situation; and/or

2. Contacting Adult Protective Service (APS) for assistance.

Surrogate Parent

Parental involvement in the planning of a child's Individual Education Plan (IEP) is a federal requirement. For a child who is without a parent willing/able to participate in the child's educational process, federal and State laws provide for the appointment, by the court, of a surrogate parent to represent a child in decisions regarding special education.

A petition for a surrogate parent for a child with disabilities may be made if any of the three following conditions have been met:

A. No parent can be identified;

B. A public agency cannot determine the whereabouts of a parent after having made three reasonable attempts; or,

C. The child is a ward of the State and the biological parent is unwilling or unable to consent to special education placement.

A person who is an employee of a State agency which is involved in the education or care of the child is not eligible to be a surrogate parent. Thus, a Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) Support Coordinator cannot be a surrogate parent. Moreover, a DES/DDD Support Coordinator cannot sign an authorization for a special education evaluation or an authorization for services for a child who has a developmental disability.

Procedures

If a child who is receiving services through DES/DDD has a surrogate parent, this information must be noted on the Individual Support Plan (ISP) form *DD-217 - 2 Team*

Assessment Summary, continued under guardianship status and reviewed annually. In addition, the surrogate parent must be part of the ISP team.

A foster parent who wants to be a surrogate parent should work with the Support Coordinator in making a request to the courts. While a foster parent may petition the court to receive an appointment as a surrogate parent, the court is responsible for determining whether a particular individual is able to act as a foster parent, and also represent the best interest of the child as a surrogate parent.

If the Support Coordinator believes a surrogate parent is necessary, e.g., the natural parents have relinquished their rights, the Support Coordinator should seek to have a surrogate parent appointed so that decisions regarding the child's education can be made in a timely manner.

The Arizona Department of Education (ADE) has information regarding surrogate parents and usually has a list of persons who have volunteered to be surrogate parents and have already received the required training.

1005-C AUTHORIZED REPRESENTATIVE FOR ALTCS BENEFITS

REVISION DATES: 10/28/2020, 9/01/2014
EFFECTIVE DATE: July 31, 1993

If there is a legal representative, that person must file the application for Arizona Long Term Care Service (ALTCS) benefits or authorize someone else to be the authorized representative. This is a person who is authorized in writing by an applicant or legal representative to represent him/her in the application process.

The authorized representative signs an affirmation to having knowledge of the applicant's circumstances, has been informed and understands the responsibilities which include:

1. Providing complete and accurate information, to the best of his/her knowledge, regarding the applicant's income, resources, household composition, citizenship, residency, and medical insurance coverage;

2. Providing all documents needed to determine eligibility;

3. Notifying the local ALTCS office of any change in the applicant's circumstances within 10 working days of the occurrence;

4. Signing all forms necessary for completing the application and verifying eligibility; and

5. Identifying and filing insurance claims and assigning insurance benefits to AHCCCS.

NOTE: Generally, a family member or a legally appointed guardian assumes the responsibility of being an authorized representative for an individual applicant. The Support Coordinator may assist in the process of making application.

1005-D REPRESENTATIVE PAYEE

REVISION DATE: 11/16/2022, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: 20 C.F.R. 404.2001-404.2065; 20 C.F.R. 416.601-416.665; A.R.S. § 36-557(O); Division Operations Policy 4004-A

PURPOSE

This policy outlines the responsibilities for the Division when a Member needs or has a Representative Payee.

DEFINITIONS

1. "Fee for Service Representative Payee" means an organization that is approved by the Social Security Administration (SSA) to perform the role of Representative Payee and to collect a monthly fee from a member's benefit payment to perform the service.
2. "Member" means an individual enrolled with the Division.
3. "Representative Payee" means an individual or organization appointed by the Social Security Administration (SSA), Railroad Retirement, Veteran's Benefits, and Civil Service to receive and manage benefits.

4. "Social Security Benefits - Social Security (SSA, Title II)" means a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner.
5. "Supplemental Security Income (SSI), Title XVI" means a federal income maintenance program for the aged, blind, and disabled persons with few or no resources.

POLICY

A. DIVISION REQUIREMENTS

1. The Division shall serve as Representative Payee for adult Members that meet all of the following criteria:
   a. The Member receives SSA, SSI, Railroad Retirement, Veteran's Benefits, Civil Service, or other benefits.
   b. The Member or guardian requests the Division to serve as Representative Payee.
   c. The Member does not have natural supports who are willing or able to manage his or her funds.
   d. The Member cannot afford a Fee for Service Representative Payee.

e. The Support Coordinator and Planning Team requests the Division to serve as Representative Payee.

f. The Member does not have an outside bank, credit union or other account established on their behalf.

2. The Division shall serve as Representative Payee if the Member is a child and meets all the following criteria:

a. The Member is eligible for SSA and/or SSI;

b. The Member is under the care and custody of the Department of Child Safety; or

c. The Member is under the care and custody of the tribal social service agency; and

d. The Member's placement is provided and paid by the Division.

3. The Division shall request approval from the organization providing the Member's benefits to serve as Representative Payee if the Member meets the criteria in A.1. or A.2. above.

4. The Division shall manage a Member's employment earnings upon the Member's request and if the Division is providing the member Representative Payee services.

B. DIVISION REPRESENTATIVE PAYEE RESPONSIBILITIES

1. The Division, as Representative Payee, shall use the funds they manage for the exclusive use and benefit and in the member's best interest.
2. When managing the Member's funds, the Division shall:
   a. Establish an individual account for the Member;
   b. Distribute the Member's funds in accordance with the requirements of the entity providing the benefits to the Member;
   c. Keep an accounting of the funds received and distributed; and
   d. Safeguard and secure the Member's funds.
3. The Division, as Representative Payee, shall report annually to the organization providing benefits to the Member the following information:
   a. How the Member's benefits were used;

b. The amount of the Member's benefits saved;

c. Any changes in the Member's living arrangements; and

d. Other information as required or requested by the organization providing benefits to the Member.

4. The Division shall, if necessary documents are made available by the Member, report a Member's employment earnings as required by SSA, if the Division:

a. Is Representative Payee for a Member receiving SSA/SSI benefits; and

b. Is managing the Member's employment earnings.

C. SUPPORT COORDINATION RESPONSIBILITIES

1. The assigned Support Coordinator shall complete and submit a DDD-1822A Request for DES/DDD to Become Representative Payee-Adult form to Member Funds if a Member meets the requirements in A.1. above and requests Representative Payee services from the Division.

2. The Support Coordinator shall complete and submit a DDD-1831A Request for Division of Developmental Disabilities to

become Representative Payee-Child form to Member Funds if the Member is a child and meets the criteria in A.2. above.

3. If the Member requires a Representative Payee, but does not meet the criteria in A. to receive Representative Payee services from the Division, the Support Coordinator shall:
   a. Refer to the Member to the SSA website or local SSA office; and
   b. Coordinate with the Member and Planning Team in finding natural or community supports for Representative Payee services.
4. The Support Coordinator shall document if a Member has a Representative Payee, whether through the Division, community, or a natural support, in the Person-Centered Service Plan.
5. The Support Coordinator shall, if agreed to by the Member, include the Member's the Representative Payee in Planning Team meetings.
6. The Support Coordinator shall complete the DDD-0221A Spending Plan form within the Member's monthly budget as part

of the Person-Centered Service Plan for Members for whom the Division is Representative Payee.

7. The Support Coordinator shall only authorize up to $499.00 for Member funds disbursement requests.
8. The Support Coordinator's Supervisor or Designee shall approve or deny Member funds disbursement requests over $500.00.

1007 SUPPORTING SEPARATED OR DIVORCED FAMILIES

EFFECTIVE DATE: December 7, 2022

REFERENCES: A.R.S. § 25-403.06

PURPOSE

This policy sets forth guidance on working with parents or guardians of Division of Developmental Disabilities (DDD) Members, when the parents or guardians are separated or divorced, in order to ensure continuity of communication for planning and implementing Member services.

DEFINITIONS

1. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
2. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. DOCUMENTATION

1. When the Support Coordinator becomes aware that a Member's parents or guardians are separated or divorced, the Support Coordinator shall request a copy of the court ordered custody

agreement or Parenting Plan to be placed in the Member's file.

2. The Support Coordinator may initiate services or implement changes in the Member's services, including change of providers, prior to the requested custody agreement or Parenting Plan being received when:
   a. Both parents or guardians are involved in the planning process, and
   b. Both parents or guardians agree with the proposed changes.
3. When the Support Coordinator becomes aware that any court-approved changes have occurred to the custody agreement or Parenting Plan, the Support Coordinator shall request a copy to be placed in the Member's file.
4. When the Support Coordinator becomes aware of any updates to any informal agreements, after finalizing the custody agreement or Parenting Plan, the Support Coordinator shall request a notarized copy of this information be placed in writing by both parties, and placed in the Member's file.

B. COMMUNICATION

1. Division staff shall send information to both parties equally, in the same manner whenever possible, when both parties have joint legal custody.
2. When Division staff respond to communication from one party, staff shall document the discussion in an email to both parties to confirm the conversation.

C. PLANNING MEETINGS

1. The Support Coordinator shall include both parties and the Member in service planning meetings, at mutually agreeable times and locations, unless both parties agree that one person shall be the representative decision maker.
2. The Support Coordinator is not responsible for scheduling two separate meetings when parents or guardians do not wish to interactively participate in the same planning meeting.
3. The Division may grant separate meetings if one party has a Protective Order against the other party. If the Division is aware of a Protective Order, the Support Coordinator shall obtain a

copy of the Protective Order file in the Legal section of the Member's file.

4. The Support Coordinator shall first attempt to schedule meetings in the Member's home, however, meetings can be held at a neutral location such as a Division office.

5. If a required meeting cannot be scheduled because of the failure of the parties to reach agreement on time or location, please see Section E.

D. ASSESSING SERVICES

1. When parents share joint legal custody, the Division shall provide services in the parents' homes or in the community in the same percentage of time outlined in the custody agreement or Parenting Plan, unless otherwise agreed to by both parties.

2. Division staff shall support goals for skill development as mutually agreed upon by the planning team. If more than one Qualified Vendor or Independent Provider is in place for a teaching/Habilitative service, Division staff shall assist the

planning team with coordinating the teaching strategies within both parties' homes as skills are more likely to be generally applied to other settings.

3. The Division may complete home modifications in the home where the Member spends the majority of their time to meet the Member's accessibility needs, as determined medically necessary by the home modification assessment. When the Member also lives part-time with the other party, home modifications may also be provided in the other party's home, at the time the other party chooses to have an assessment to determine medically necessary home modifications to meet the Member's accessibility needs at that home environment.

E. CONFLICT RESOLUTION

When parents with joint legal custody cannot agree, despite facilitation by Support Coordination staff, the Division shall not initiate new services or implement changes in the Member's services, including change of providers.

3001 FAMILY MEMBERS AS PAID PROVIDERS

REVISION DATE: 2/26/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

A. Natural Child;

B. Natural Sibling;

C. Adoptive Child;

D. Adoptive Sibling;

E. Stepchild or Stepsibling;

F. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law;

G. Grandparent or Grandchild; and, or,

H. Spouse of Grandparent or Grandchild.

Immediate relatives not permitted to provide services for children under age 18 include:

A. Natural Parent;

B. Adoptive Parent ; and,

C. Step Parent.

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services;

B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse (See Attendant Care section for exception);

C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources;

D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or Habilitation (skilled care includes, but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers, or suctioning tracheostomy care) (See Appendix D – Skilled Nursing Matrix);

E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service;

F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws, and rules;

G. Primary caregivers/parents may not be paid to provide Respite;

H. Services shall not replace care provided by the person's natural support system;

I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division;

J. Qualified family members may become certified home and community based service providers by meeting the certification requirements, as applicable; and,

K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

3003 SELECTION OF PROVIDERS

REVISION DATES: 3/02/22, 3/22/21, 2/05/18, 6/10/16
EFFECTIVE DATE: 10/04/14
REFERENCES: A.A.C. R6-6-2101 thru R6-6-2115

PURPOSE

To provide a person-centered approach for the Division of Developmental Disabilities (Division) members to select providers in a fair and equitable manner. The Division does not discriminate against Qualified Vendors/Independent Providers who serve high-risk populations or who specialize in conditions that result in costly treatment due to Division members selecting their own providers.

Division staff are not permitted to show favoritism toward any specific Qualified Vendor/ Independent Provider. If staff are asked to make a recommendation regarding a Qualified Vendor/Independent Provider, staff must explain to the member/responsible person that they cannot make a specific recommendation. Staff will then review the methods that are available for the member to select a Qualified Vendor/Independent Provider. The Division may assist the member/responsible person to identify the criteria needed to make a selection based on the member's needs.

I. POLICY

A. IDENTIFYING THE NEED FOR SELECTING A QUALIFIED VENDOR

1. The selection of a Qualified Vendor is needed when:
    a. A new service is approved by the Division, or
    b. A member/responsible person requests a change of Qualified Vendor.
2. If the member/responsible person requests a new Qualified Vendor at the time of the annual planning meeting:
    a. The request will be documented in the Planning Document.
    b. The Division will accommodate the requests to the extent appropriate and practical.
3. If the member/responsible person requests a new Qualified Vendor outside of an annual planning meeting:
    a. The request must be in writing or reported directly to the Division for incorporation into the member's record and include:
        i. The rationale for changing Qualified Vendors, and
        ii. A description of the opportunities given to the current Qualified Vendor to address the member's concerns.

4. If there is team agreement to make the change, the Division will accommodate the requests to the extent appropriate and practical.

5. If there is no team agreement, the Division shall schedule and convene a resolution meeting as soon as possible, document steps to resolve the concern(s), and monitor the plan for the following 21 days to determine if the concerns have been resolved. If the concerns have not been resolved, the Division will accommodate the requests to the extent appropriate and practical.

II. NON-RESIDENTIAL SERVICES

A. METHODS FOR SELECTING A QUALIFIED VENDOR - NON-RESIDENTIAL SERVICES

1. When a non-residential service is approved by the Division, or a change of Qualified Vendor for a non-residential service is needed, the member/responsible person may identify a Qualified Vendor in the following ways:

   a. The member may identify a Qualified Vendor or contracted Independent Provider without assistance from the Division. The Division will issue a vendor call concurrently to ensure that services are put in place.

   b. If requested by the member/responsible person, the Division may provide an electronic or printed copy of the Qualified Vendor or Independent Provider Directory, or direct the member/responsible person to use the online Provider Search option available on the Division's webpage, "Assistance for Individuals or Families."

   c. The member/responsible person will confirm the potential Qualified Vendor's availability with the Division.

2. The member may select a Qualified Vendor through the use of a vendor call issued by the Division. A vendor call for non-residential services is a notice from the Division inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific member or specific group of members, based on the requirements defined in the member's Planning Document.

B. SELECTING A QUALIFIED VENDOR USING A NON-RESIDENTIAL VENDOR CALL

1. Vendor calls for non-residential services remain open and/or continuous until the service is assigned.

2. The Division provides the member/responsible person with responses that meet the criteria of the vendor call as they are received.

3. After receiving the first response to the vendor call from the Division, the member/responsible person must select a Qualified Vendor from the responses received within seven calendar days.

4. If a member/responsible person is not willing to, is unable to, or does or does not select a vendor, a Qualified Vendor may be auto assigned on their behalf by the Division. The member/responsible person will be notified of the auto-assignment.

5. The selection will be documented in the member's file and progress notes.

C. QUALIFIED VENDOR NOT IDENTIFIED – NON-RESIDENTIAL VENDOR CALLS

1. When a non-residential vendor call does not receive any Qualified Vendor responses, the Division will use direct referral to individually contact one or more of the Qualified Vendors who provide services in the geographic area of the member. If necessary, the Division may extend the search to proximal areas or statewide.

2. Negotiated rate considerations and/or out-of-network providers may be utilized by the Division if a Qualified Vendor is not identified using the vendor call and direct referral process.

3. Alternative services will be offered, assessed, and documented in the member's file by the Division while a Qualified Vendor is being identified.

III. RESIDENTIAL SERVICES

A. METHODS FOR SELECTING A QUALIFIED VENDOR - RESIDENTIAL SERVICES

1. When a residential service is approved by the Division, or a change of Qualified Vendor for a residential service is needed, the member/ responsible person may identify a Qualified Vendor in the following ways:

   a. The member/responsible person may identify a currently contracted Qualified Vendor on their own; however, the Division must confirm that the selected Qualified Vendor has an existing/current funded capacity that can meet the member's needs prior to the authorization of services.

   b. The member/responsible person may select a Qualified Vendor through the use of a vendor call issued by the Division. A vendor call for residential services is an invitation to Qualified Vendors to provide services for a specific member, based on the member's individual needs.

B. SELECTING A QUALIFIED VENDOR USING A RESIDENTIAL VENDOR CALL

1. Vendor calls for residential services close after five calendar days.

2. When Qualified Vendor responses to residential vendor calls are received, the Division provides the member/responsible person with the responses that met the criteria in the vendor call after it closes.

    a. The member/responsible person must select a Qualified Vendor from the responses within five calendar days of receiving the response list from the Division. The member/ responsible person may request an additional five calendar days to select a Qualified Vendor, if needed.

    b. If a member/responsible person is not willing to, unable to, or does not select a vendor within the allotted time frame, a Qualified Vendor may be auto assigned on their behalf by the Division. The member/responsible person will be notified of the auto-assignment.

3. The selection will be documented in the member's file and progress notes.

C. QUALIFIED VENDOR NOT IDENTIFIED - RESIDENTIAL VENDOR CALLS

1. When a residential vendor call does not receive any responses, the Division will determine if the parameters of the vendor call need to be adjusted.

2. If the parameters of the vendor call are adjusted, a new vendor call will be issued.

3. If the parameters of the vendor call cannot be adjusted, the Division will use direct referral to individually contact one or more of the Qualified Vendors who provide services in the preferred geographic area of the member.

4. The Division may identify the need to expand the Network when there are no responses to vendor calls/direct referrals for two or more members.

5. Negotiated rate considerations may be utilized at the discretion of the Division.

6. Alternative services may be offered, assessed, and documented in the member’s file by the Division while a Qualified Vendor is being identified.

7. Under rare circumstances the Division may consider the use of an out-of-network provider for emergent needs.

IV. INDEPENDENT PROVIDERS

A. SELECTING INDEPENDENT PROVIDERS

1. Members may select to receive services from an existing independent provider who has an Independent Provider Agreement with the Division. Beginning in 2019, the Division stopped expanding the Independent Provider Program. Exceptions may be considered on a case-by-case basis and only if there is no network sufficiency to meet a specific member's needs.

2. A member/responsible person may change Independent Providers at any time.

3. Independent Providers are paid a rate based on member assessment.

4. The Division requires the use of a fiscal intermediary to manage the tax responsibilities and other employer obligations related to Independent Provider selection.

5. The fiscal intermediary is responsible for:

    a. Paying claims submitted by Independent Providers, including tax obligations;

    b. Tracking authorized service hours; and

    c. Working with the member/responsible person and the Division to resolve any financial concerns.

B. REQUIREMENTS FOR MEMBERS USING INDEPENDENT PROVIDERS

1. When a member/responsible person selects an existing Independent Provider to provide the service, the member/responsible person shall:

    a. Hire, orient, and train each Independent Provider to deliver the support as authorized in the Planning Documents;

    b. Review and approve each Independent Provider timesheet;

    c. Track the hours of service used compared to the hours of service authorized by the Division; and

    d. Report any concerns about the Independent Provider or the Independent Provider program to the Division and work with the fiscal intermediary and Division staff toward resolution.

3004 RESERVED

3005 RESERVED

3006 SHORT TERM EMERGENCY SITUATIONS (RESIDENTIAL AND DAY PROGRAMS)

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.A.C. R6-6-2110

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include, but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee *and* the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, or e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen ([15]) calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.
Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

A. The change in behavior or condition that precipitated an emergency situation;

B. The actions being taken to assist member (e.g., medical or psychiatric appointment, arranging for positive behavioral support, grief counseling);

C. The projected date of completion for each step; and,

D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within (21) calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV's request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.

3007 SERVICE PROVIDER INFORMATION, AUTHORITY, AND NOTIFICATION

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 3, 1993

The Division shall disclose to a service provider in the Planning Document, and in all meetings resulting from a response to a Vendor Call for Services, any historical and behavioral information necessary for the provider to anticipate the member's future behaviors and needs. This includes summary information from the Program Review Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and Behavioral Health Treatment Plans. The Division shall redact the member's identification from this information.

Service providers are authorized to engage in the following activities in accordance with the member's Planning Document:

A. Administer medications, including assisting the member's self-administration of medications;

B. Log, store, and dispose of medications; and,

C. Maintain medications and protocols for direct care.

The Division may establish procedures for items "A" through "C" listed above.
To protect the health and safety of a member, a provider must notify the Division within 24 hours if an emergency situation exists in which the provider is unable to meet the health or safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15 days after notification to recommend any changes, including whether there is a need for temporary additional staffing to provide appropriate care for a member, and shall develop a plan within 30 days after notification to resolve the situation.

<u>Other Safety Considerations for Placements</u>

Prior to any out-of-home respite or residential placement (including emergencies), the *Pre-Service Provider Information*, *Residential Transfer Checklist* , and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the member, other residents, staff, and the public.

The Planning Team shall complete the *Case Transfer* form as part of the pre-placement meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the Department of Child Safety (DCS), or other members/agencies as appropriate, will identify

planned responses to known problems prior to placement, and document them on the *Risk Assessment*.

3008 ELECTRONIC MONITORING

REVIEW DATE:
EFFECTIVE DATE: December 27, 2023
REFERENCES: 45 CFR Part 164, A.R.S. §12-2297, A.R.S. §36-551.01, A.R.S. §36.568

PURPOSE

This policy outlines the Division's oversight and monitoring of Qualified Vendors and the use of Electronic Monitoring Devices in service sites funded by the Division.

DEFINITIONS

1. "Common Area" means areas inside and outside the home designed for use by multiple individuals, including residents. Bedrooms, toileting areas, and bathing areas are excluded from this definition, regardless of the number of individuals for which the area is designed.

2. "Electronic Monitoring Device" means the same as defined in A.R.S. § 36-568(E).

3. "Health Insurance Portability and Accountability Act (HIPAA)" means the Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21,

1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

POLICY

A. ELECTRONIC MONITORING DEVICES INSTALLED BY QUALIFIED VENDORS

1. The Division shall review and approve the Qualified Vendor's policies, procedures, and notices prior to the installation of the Electronic Monitoring Devices in the Common Areas of a group home, nursing supported group home, day treatment, or employment service site or a vehicle used for transportation.
2. The Division shall ensure Qualified Vendors only install Electronic Monitoring Devices in Common Areas.

3. Prior to installing or using Electronic Monitoring Devices in either a service site or a vehicle used for transportation, the Division shall ensure the Qualified Vendor:
    a. Notifies the Division of the intent to install devices.
    b. Complies with federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and other applicable state and federal law addressing confidentiality;
    c. Specifies in policy how Electronic Monitoring Device recordings, regardless of format, are secured to protect the confidentiality of the Members;
    d. Obtains written consent from each Responsible Person for Members who receive services at the service site;
    e. Determines in what circumstances access to the Electronic Monitoring Device recordings may be allowed;
    f. Determines which personnel may have access to the Electronic Monitoring Device recordings;
    g. Provides training to staff members who will have access to the Electronic Monitoring Devices; and

h. Posts signs at each service site entrance and in a conspicuous place in the common area and in the vehicle that is being monitored which indicates the days and hours of monitoring.

4. When the Division has approved the Qualified Vendor to use Electronic Monitoring Devices in either a service site or a vehicle used for transportation, the Division shall ensure the Qualified Vendor:

a. Maintains records created by Electronic Monitoring Devices in accordance with A.R.S. §12.2297 that can be produced upon request of the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law unless otherwise restricted.

b. Retains and has accessible any Electronic Monitoring Device recordings, regardless of format, generated by the Electronic Monitoring Devices installed and monitored by the Qualified Vendor for a minimum of 30 calendar days.

c. Evaluates all Electronic Monitoring Devices at least quarterly to ensure the Electronic Monitoring Devices are functioning properly, secure from access by unauthorized

personnel, and are being used in compliance with this Policy.

d. Monitors adherence to policies and promptly addresses non-compliance.

e. Maintains a log of all monitoring of Electronic Monitoring Devices.

f. Makes policies, training records, training acknowledgments, evaluations, and monitoring logs available to the Division as requested

5. The Division shall ensure the Qualified Vendor takes action when a Responsible Person notifies the Qualified Vendor they are no longer in agreement with the use of the Electronic Monitoring Devices by requiring the Qualified Vendor to:

a. Immediately turn off the Electronic Monitoring Devices;

b. Notify all Responsible Persons of the discontinuation of electronic monitoring in the setting;

c. Remove the Electronic Monitoring Devices within two business days.

6. The Division shall ensure that Members, living in a group home or nursing supported group home, are informed that a Qualified Vendor may allow the Responsible Persons to share in the costs of the installation, oversight, and monitoring of Electronic Monitoring Devices maintained by the Qualified Vendor when the Responsible Person agrees to the arrangement.

B. RESPONSIBLE PERSON INSTALLATION

1. The Division shall ensure Qualified Vendors permit installation of Electronic Monitoring Devices, at the expense of the Responsible Person, in Common Areas of a group home, nursing supported group home, or a vehicle used for transportation after all of the Responsible Persons consent to the use of Electronic Monitoring Devices.

2. The Division shall not permit Qualified Vendors to:

   a. Turn off or on the Electronic Monitoring Device;

   b. Cover up or in any way obscure the ability of the Electronic Monitoring Device to have full view of the area chosen by the Responsible Person;

c. Move the Electronic Monitoring Device;

d. In any other way assist or hamper the operation of and use of the Electronic Monitoring Device.

3. The Division shall ensure the Qualified Vendor takes action when a Responsible Person notifies the Division or the Qualified Vendor that they are no longer in agreement with the use of Electronic Monitoring Devices by requiring the Qualified Vendor to:

a. Immediately Stop using the Electronic Monitoring Devices;

b. Notify all Responsible Persons and the Division in writing of the discontinuation of Electronic Monitoring in the setting;

c. Ensure the Responsible Person removes the Electronic Monitoring Devices within two business days, and

d. Make any necessary repairs, at the time of removal, caused by the installation and removal of the Electronic Monitoring Devices.

C. ELECTRONIC MONITORING DEVICES IN PRIVATE SPACES INSTALLED BY THE RESPONSIBLE PERSONS

1. The Division shall ensure Electronic Monitoring Devices installed by the Responsible Person are only installed in the Member's private spaces.
2. The Division shall ensure Qualified Vendors do not prohibit the Responsible Person from installing Electronic Monitoring Devices in a Member's private bedroom, toileting area, and bathing area in a group home or nursing supported group home.
3. The Division shall not be responsible or make a Qualified Vendor be responsible to monitor the data collected from the Electronic Monitoring Devices including when the Responsible Person shares the data from the Electronic Monitoring Devices access with a third party..
4. The Division shall ensure the Qualified Vendor follows HIPAA as outlined in 45 CFR Part 164 and other compliance requirements when the Responsible Person shares the data from the Electronic Monitoring Devices with the Qualified Vendor.
5. The Division shall ensure the Qualified Vendor takes action when a Member moves out of the group home or nursing supported group home by requiring the Qualified Vendor to:

a. Ensure the Responsible Person removes the Electronic Monitoring Devices from the Member's private spaces within two business days, and

b. Makes any necessary repairs, at the time of removal, caused by the installation and removal of the Electronic Monitoring Devices.

4001 THIRD PARTY LIABILITY

REVISION DATE: 4/24/2019, 9/1/2014
EFFECTIVE DATE: January 1, 1996

Third party liability (TPL) is any funding source other than the Division of Developmental Disabilities (the Division). It includes medical insurance, for example, Medicare, CHAMPUS, TriCARE, or Blue Cross/Blue Shield. It also includes any benefits or settlements a person has as the result of an accident. It may also include eligibility for other programs such as Children's Rehabilitative Services (CRS), Arizona Health Care Cost Containment System (AHCCCS), or county funded services.

Policy

The Division is required to bill any third party for all covered services for all individuals eligible for services through the Division. A member/responsible person is required to provide third party insurance information when requested.

Retroactive Recoveries Involving Commercial Insurance Payor Sources

For two years from the date of service, the Division engages in retroactive third-party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment.

If a commercial insurance payor source is identified, the Division seeks recovery from the commercial insurance. The Division is prohibited from recouping related payments from providers, requiring providers to act, or requiring the involvement of providers in any way, unless the provider was paid in full from both the Division and the commercial insurance.

Other Third-Party Liability Recoveries

A. The Division will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The Division does not pursue recovery in the following circumstances, unless the case has been referred to the Division by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tortfeasors
- Restitution Recoveries
- Worker's Compensation Cases.

B. Upon identification of a potentially liable third party for any of the above situations, the Division reports the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case within 10 business days.

The Division may refer mass tort or total plan cases to the Division's authorized contractor. The Division will cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Cases

A. In total plan cases, the Division performs all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916 for cases pursued by the Division. The Division may retain up to 100% of its recovery collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the Division's financial liability for the member

2. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (e.g. lien filing).

3. Such recovery is not prohibited by state or federal law.

B. Prior to negotiating a settlement on a total plan case, the Division notifies AHCCCS or AHCCCS' authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. The Division must report settlement information to AHCCCS by the 10th day of each month on an AHCCCS-approved monthly file.

Joint and Mass Tort Cases

AHCCCS' authorized representative performs all research, investigation, and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Division.

In joint and mass tort cases, AHCCCS' authorized representative is also negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Division will be responsible for their prorated share of the contingency fee. The Division's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Division.

Other Reporting Requirements

A. All TPL reporting requirements are subject to validation through periodic audits and/or Operational Reviews that may include the Division's submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include but are not limited to:

- The member's first and last name
- AHCCCS ID
- Date of incident
- Claimed amount
- Paid/recovered amount
- Case status.

4002 CLIENT BILLING

REVISION DATE: 5/10/2023, 11/17/2021, 11/20/2019, 3/20/2019, 9/1/2014
EFFECTIVE DATE: January 1, 1996
REFERENCES: 20 C.F.R. § 416.1205; A.R.S. § 36-551; A.A.C. R6-6-1801; A.A.C. R6-6-2201; A.A.C. Chapter 6, Article 12, Cost of Care Portion

PURPOSE

The purpose of this policy is to outline the requirements for Members to financially contribute to the cost of services provided by the Division.

DEFINITIONS

1. "Administrative Review" means an informal review of a decision made by the Division.
2. "Cost of Care Portion" means the percentage of the cost of a Member's care that a Responsible Person or Representative Payee may be required to pay to the Division to offset the cost of the Member's care. The percentage of the cost of care is calculated based on the Member's income and based on 200% of the federal poverty guidelines.
3. "Home and Community Based Services" or "HCBS" means one or more of the following services provided to clients: attendant care, day treatment and training for children or adults, habilitation, home health

aide, home health nurse, hospice care, housekeeping-chore or homemaker, non-emergency transportation, occupational therapy, personal care, physical therapy, respiratory therapy, respite services, speech therapy, supported employment, and other comparable services as approved by the AHCCCS Director.

4. "Maximum Allowable Limit" means the highest amount of an individual's income or assets permitted by the Social Security Administration for Supplemental Security Income eligibility. This amount is also used by the Division to determine the Member's Cost of Care Portion.
5. "Member" means the same as "Client" as prescribed in A.R.S. § 36-551.
6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

7. "Representative Payee" means an individual or organization appointed by the Social Security Administration, Railroad Retirement, Veteran's Benefits, and Civil Service to receive and manage benefits.
8. "Residential Services" or "Room and Board" means a living arrangement operated by the Division or by a Service Provider, in which Members live with varied degrees of appropriate supervision.
9. "Special Needs Trust" means a legal arrangement that enables a person with a disability to hold assets and maintain his or her eligibility for public assistance benefits.

POLICY

A. FINANCIAL CONTRIBUTION

1. The Division shall require Members receiving services from the Division to make a financial contribution to the cost of their care based on their eligibility:
    a. ALTCS Members shall only pay for the Cost of Care Portion for Residential Services.
    b. Non-ALTCS Members shall pay for the Cost of Care Portion for all program services including Residential Services.

2. The Division shall bill Members receiving state-funded services who have a trust, annuity, estate, or assets exceeding the Maximum Allowable Limit of $2,000, including Special Needs Trusts set up outside the State of Arizona, to their Cost of Care Portion for all programs and services provided by the Division.
3. The Division shall not bill Members receiving state-funded services who have a Special Needs Trust set up within the State of Arizona.

B. FINANCIAL CONTRIBUTIONS AND BILLING FOR RESIDENTIAL SERVICES (COST OF CARE PORTION)

1. The Division shall calculate the Member's Cost of Care Portion based on the amount of income or benefits the Member receives, including Social Security, Veteran's, and Railroad Retirement benefits.
2. The Division shall use the Federal Poverty Guidelines on the Health and Human Services Website to calculate a Member's Cost of Care.

3. The Division shall base the Cost of Care Portion for a Member receiving Residential Services on the total amount of income and monthly benefits the Member receives as follows:
    a. The required financial contribution is a maximum of 70% of the Member’s income and monthly benefits the Member receives, but must not exceed the actual cost of Residential Services.
    b. The Division shall, when the Member's personal savings exceeds the Maximum Allowable Limit of $2000 of the monthly federal benefits, calculate the billing amount as follows:
        i. For the ALTCS Member, the actual cost of Residential Services until the Member’s personal savings drops below the Maximum Allowable Limit of $2,000.
        ii. For the non-ALTCS Member, the actual cost of all services, including Residential Services, until the Member’s personal savings drops below the Maximum Allowable Limit of $2,000.

4. The Office of Accounts Receivable and Collections shall notify the Responsible Person or Representative Payee of the amount the Member must pay each month for Residential Services.
5. The Responsible Person or Representative Payee may contact the Division to request one or more of the following based on financial hardship of the Member:
    a. A financial review;
    b. An Administrative Review; or
    c. A reduction in the amount billed.
6. The Division shall require the Responsible Person or Representative Payee to report any lump sum of past due benefit payments from the benefit source to the Division and shall bill against the lump sum amount.

C. FINANCIAL REVIEW

1. The Responsible Person or Representative Payee may request a financial review of the Member's Cost of Care Portion payment amount, by requesting in writing any of the following:
    a. An informal business review.

i. The Division's Business office shall conduct an informal business review when requested by the Responsible Person or Representative Payeeat any time.

ii. The Responsible Person or Representative Payee shall submit the request via email to dddrevenuedesk@azdes.gov and include recent tax forms.

iii. The Division shall respond to the Responsible Person or Representative Payee within 10 business days from receipt of the request.

b. An Administrative Review as prescribed by A.A.C. R6-6-1801 et seq with appeal rights as prescribed by A.A.C. R6-6-2201.

i. The Responsible Person or Representative Payee, shall, at any time within 30 days of the date payment for the Cost of Care Portion is due, submit a request to the Division's Office of Administrative Review at dddofficeofcompliance@azdes.gov.

2. The Responsible Person or Representative Payee may request an Administrative Review without requesting an informal business review.

D. HARDSHIP REDUCTION REQUEST

1. The Responsible Person or Representative Payee may request a hardship reduction of the Cost of Care Portion by submitting a DDD-1532A Hardship Reduction Request form with documentation of expenses to the Division at DDDCORRBHSBilling@azdes.gov.
2. The Division shall review hardship reduction requests for any of the following expenses:
    a. Medicare Part D prescription drug co-payments, when submitted with proof of out-of-pocket expenses.
    b. Amounts ordered by a court for restitution, child or spousal support, when documentation of the order is submitted.
    c. Amounts paid for services provided by and items prescribed by a licensed healthcare professional, when documentation of the expenses supporting the request

and denial(s) from third party payers, or other potential sources of assistance are submitted.

d. Expenses for an extraordinary circumstance that affects the Member's health and safety when documentation of the amount of the expense, and the effect on the Member's health and safety if the expense is not incurred is submitted.

e. Cost of a prepaid burial or cremation plan when supported by documentation of the cost and the length of the payment period.

3. The Division shall review hardship reduction requests that include current documentation of the expenses supporting the request and shall issue a written determination within 30 business days that:

a. Approves a temporary reduction of the Cost of Care Portion billing amount for up to 12 months, or

b. Denies the request.

4. The Responsible Person or Representative Payee may, if they disagree with the Division's hardship reduction request

determination, submit a request for an Administrative Review no later than 30 days following the date of the notice as per A.A.C. R6-6-2201.

5. Upon request by the Division, the Responsible Person or Representative Payee shall provide verification that the expense for which a hardship reduction request was granted has been paid.
6. The Responsible Person or Representative Payee may submit a hardship reduction request at any time as long as the incurred cost is not older than six months.

4003 ADMINISTRATIVE REVIEW / APPEAL AND HEARING RIGHTS

REVISION DATE: 9/1/2014
EFFECTIVE DATE: January 1, 1996
REFERENCES: A.A.C. 6-6-22 (R6-6-2201 et seq.).

A. The Division will issue a written decision within thirty (30) calendar days from receipt of the request for Administrative Review. Appeal of this decision is available as prescribed by A.A.C. Title 6, Chapter 6, Article 22 (R6-6-2201 et seq.).

B. If Administrative review is based on notice of an increase in the monthly billing amount, the billing amount shall not increase until the Department has issued its final decision.

C. If the Administrative Review decision or an appeal of an Administrative Review decision results in affirmation of the original order in whole or in part, the monthly billing liability shall be retroactively effective from the date of the original notice of the billing amount. The person liable for the cost of care shall pay all amounts as stated in the original notice, as adjusted (if any adjustment in the amount is made by Administrative Review or the appeal). The Department's final decision on the billing amount will be retroactively effective beginning with the month in which the request for Administrative Review was made. Failure to pay the amounts owed may result in termination of services.

4004 OVERVIEW

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

This chapter explains Department of Economic Security (DES) policies for safeguarding, using, and investing funds for members in the Division of Developmental Disabilities (DDD).

4004-A MEMBER FUNDS - DEFINITIONS

REVISION DATE: 09/30/2020, 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 36-557(O), A.A.C. R6-6-1204, A.R.S. §36-2901, Supplemental Security Income (SSI), Title XVI, A.A.C. R6-6-1204.

A. Member Funds System – A system used by the Division of Developmental Disabilities (the Division), to maintain and track member funds.

B. Fiduciary Capacity – The capacity in which a person will properly and faithfully account for all member funds received by him/her. A person who is trusted to handle member funds is acting in a fiduciary capacity. Fiduciaries may include any employee of the State of Arizona or a private provider under contract.

C. Individual Service Plan (ISP) Spending Plan - The Planning Team is required to complete the following form, *ISP Spending Plan (DD-221-FF),* to set the expectation for how the member's money will be spent in the upcoming year.

The Division Support Coordinator and the Division Member Funds Unit are responsible for managing the funds to maintain Arizona Long Term Care Services (ALTCS) and SSI program eligibility. All members for whom the Division is the Representative Payee, and all members living in licensed residential settings, are required to complete a *DD-221-FF* form each year.

D. Legal Guardian or Conservator – An individual appointed by the court of law responsible for a minor or an incompetent adult. The Social Security Administration (SSA) does not automatically select a legal guardian or conservator as payee for a beneficiary. Instead, SSA will make independent judgments in every case to determine who will best serve the beneficiary as payee. This may or may not be a legal guardian/conservator.

E. Member Funds - Funds entrusted to an individual or agency for safeguarding and investment. The requirements for this are found in the instrument establishing such funds, and by Division Policy and Internal Instruction Manuals. The source of funds may include any of the following:

- Cash
- Checks
- Money orders
- Petty cash funds
- Change funds
- Bank accounts
- Savings accounts and investments

- ACH/Electronic

F. Planning Document – The general term for the Individual Support Plan (ISP), Individualized Family Services Plan, or Person-Centered Plan. The Planning Document includes an ISP - Spending Plan, as appropriate.

G. Personal Spending Money – The discretionary funds and allowances provided to members.

H. Provider - A provider is any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. Qualified Vendors are Providers.

I. Railroad Retirement Annuities and Pensions – The comprehensive benefit program created in the 1930s, for railroad employees who retired and included their families and survivors. For more information on this benefit, contact the Railroad Retirement Board and request form: *IB-2*.

J. Representative Payee - Individual or organization appointed by Social Security to receive and manage the social security or SSI benefits of another person. A representative payee must use the funds they manage for the exclusive use and benefit and in the member's best interest.

Requirements for a Division Representative Payee:

1. When no one is willing or able to perform the Representative Payee duties, or a member cannot afford the monthly fee to pay for this service, the Division may request that the Social Security Administration appoint them to become the representative for the member. When the Division is the Representative Payee, the Support Coordinator and Member Funds are responsible for managing member funds.

2. Pursuant to Arizona Revised Statutes (A.R.S.) § 36-557(O), a service provider may serve as a representative payee if requested by the member or the member's guardian and approved by the payer.

K. Residential Services – the services that include Room and Board, and daily Habilitation may be provided in one of the following settings: Group Home; Developmental Home; Nursing Supported Group Home.

Residential Room and Board is not a reimbursable service under ALTCS; therefore, it is the only residential service that is billable under the Arizona Administrative Code (A.A.C.) R6-6-1204.

L. Social Security Benefits - Social Security (SSA, Title II) is a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner. A worker's spouse or children may become eligible for Social Security upon the worker's attainment of a certain retirement age, disability or death, if the worker becomes disabled or dies. The amount someone receives depends upon the age of the wage earner, the length of time worked

and the amount they earned from which Federal Insurance Contributions Act (FICA) taxes were withheld.

For more information regarding Social Security, visit the Social Security website at www.ssa.gov.

Supplemental Security Income (SSI), Title XVI, is a federal income maintenance program for the aged, blind, and disabled persons with few or no resources. The person must be blind, or disabled, or 65 or older, have limited income, and cannot have over $2,000 in allowable resources.

M. Veterans Benefits – Benefits payable to surviving spouses and dependents of military personnel who die while in active military service and to survivors of veterans who died after active service.

4004-B MEMBER FUNDS SYSTEM

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: DDD Operations Policy, 1005-D Representative Payee

When the Division of Developmental Disabilities (the Division) is approved by the Social Security Administration (SSA) to become the Representative Payee for a member (reference *DDD Operations Policy 1005-D Representative Payee*), Member Funds will establish a collective saving and checking account.

The collective saving and checking accounts and are comprised of:

A. Social Security Benefits (RSDI or SSA)

B. Social Security Income (SSI)

C. Wages earned by the member

D. Railroad Retirement (RR)

E. Veterans Benefits (VA)

F. Revenue from personal trust funds and estates

G. Monetary gifts

H. Earned interest

I. Other Sources.

J. Stipends

K. Civil Service

The Division will serve as the Representative Payee of last resort, when a member has no one else willing, or able, to manage his or her funds and cannot afford a Fee for Service Representative Payee.

The Division will not serve as Representative Payee when any outside bank, credit union, and other accounts have been established or opened on member's behalf. Separate accounts make it impossible to assure that the member's financial eligibility level for benefits or Arizona Long Term Care System Service (ALTCS) is not exceeded, including Achieving a Better Life Experience (ABLE) Accounts.

A member who can establish an ABLE account or other account has identified a "party" willing to manage his or her funds and can afford a Fee for Service Payee. Upon request to transfer monies from a Member Fund account into an ABLE account, the member's Support Coordinator, the member, and Social Security will be given a three – month notice of intent for the Division to discontinue as the Representative Payee. Failure to identify a new Representative Payee by the end of the 90-day notice period may result in Social Security suspending the member's benefits.

Division employees are prohibited from offering assistance or help an individual complete income tax forms unless they are the legal guardians for the members.

A. For the Division to become a Representative Payee for a member, the Support Coordinator must submit one of the following forms via email to the DDD DS Client Fund (DDDDSClientFund@azdes.gov): The DS stands for District South, DS is the only district that has a client funds unit we are statewide unit

1. For children, complete this form: *Request for DES/DDD to Become Representative Payee-Child (DDD-1831A).*

2. For adults, complete this form *Request for DDD to Become the Representative Payee (DDD-1822A*).

4004-D RESPONSIBILITIES

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. Support Coordination District Program Administrators and Managers are ultimately responsible for the proper use of the member funds.

B. The Division of Developmental Disabilities Business Operations and Client Funds will:

1. Ensure training, assistance, and technical guidance is provided to all employees responsible for member funds.

2. Exercise good judgment and due diligence in the administration of member funds.

3. Audit and provide administrative assistance to review activity related to member funds.

C. Confidentiality will be maintained in accordance with *Chapter 6001-A Confidentiality* of the Operations Policy Manual.

D. No Division employee shall offer assistance or in any way help an individual complete income tax forms, unless they are the legal guardians for the member.

4004-E SAFEGUARDING MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

Purpose

This policy establishes the Division of Development Disabilities (the Division, DDD) responsibilities as the Representative Payee Management of Accounts.

Separate Accounts

A. A separate accounting must be maintained for each member. The accounting must show all funds received or disbursed, and remaining balances.

B. Transactions posted to a member's Client Funds account must be traceable to an original source document, such as a *Request for Client Funds (DDD-1833A)*, a receipt, invoice, or bill, etc.

C. Electronic transfers to withdraw funds from member accounts are not allowed. An electronic transfers to deposit funds from the member's earned income source(s) must have prior authorization from the Client Fund Unit

Fund Transactions

A. All funds received must be documented through the Client Fund System.

B. Checks and other negotiable instruments received must be logged on a daily basis and endorsed with the restrictive statement, as follows:

- AZ DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF DEVELOPMENTAL DISABILITIES
- ACCOUNT NUMBER
- FOR DEPOSIT ONLY

C. Funds received must be deposited in the designated bank account in a timely manner. Appropriate safeguards must be present while funds are transported between the Division's facility and the bank.

D. The same person must not handle a transaction from beginning to end. If personnel and other resources permit, deposits, cash/check logging, client funds duties, and administrative functions will be separated.

E. The Client Fund System Manager acts in a fiduciary capacity, which includes responsibility to account for all funds in the Client Fund System.

Insurance purchased for members in the Client Fund System such as life or burial insurance must not list as beneficiary any of the following: any of the following as a beneficiary:

1. The Division
2. An employee of the Division
3. A paid contracted provider
4. An employee of a provider.

However, a family member who is also an employee of the Division or a provider may be listed as a beneficiary. Additionally:

- Any policy purchased must be of no cash value.
- Any policy purchased must show that the member is the sole owner of the policy.

F. All transactions and record keeping must be done confidentially. Only those who have been approved by the Division are allowed to review and to work with member records.

G. The Client Funds Unit will only release information directly to DDD Support Coordination, Social Security, Revenue Desk, ALTCS, and Office of Inspector General.

4004-F MEMBER FUNDS SECURITY

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Member funds will be kept in a secure safe or locked location until deposited. When the Fund Manager leaves the work area, the safe or other location shall be locked.

Funds shall not be stored in desks, unlocked files, purses, or other places that are not secure.

Computer access to member information shall be restricted by secure passwords. No one other than the fund manager and/or designee shall have knowledge of the safe key/combination or the password to secure files.

The District Business Operations Manager or designee shall reconcile member accounts monthly. The administrator of business operations must approve any exceptions.

4004-G DISBURSING MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. All disbursements will be by pre-numbered checks.

B. All disbursements, except by authority of the Support Coordination District Program Manager/Lieutenant Program Manager (DPM/LPM), must be authorized in the Individual Spending Plan.

C. All disbursements require the following:

1. Disbursements shall be documented by written requests for funds.

2. Any request over $500 must be approved by the Support Coordination Supervisor or a designee of equal to or higher ranking.

3. Documentation of the amount of each ongoing deduction for any billings including but not limited to residential.

4. Excess funds are not to be used for non-approved purchases. If disbursed funds exceed the cost of the approved purchase, these excess funds shall be returned to the member's account with a reconciliation statement accounting for purchases.

   The person processing an expenditure cannot be the payee of the check. Nor will the person maintaining accounting records or preparing checks also sign the checks.

D. All pre-numbered checks will be accounted for monthly in the following categories to aid in the bank reconciliation process:

1. Paid by bank (cancelled)

2. Void

3. Outstanding

4. Suspense File: Cash or checks in the hands of third parties for the purchase of goods and services for members will be signed for and a suspense file established pending paid receipts. Suspense files will be cleared within thirty days after full payment for goods and services.

E. It is the policy of the Social Security Administration that individuals shall be provided at least $30 monthly for their personal needs.

1. Member personal spending paid directly to the member does not require receipts.

2. However, any personal spending money not paid directly to the member requires supporting documentation verifying the use of these funds. Those entities required to account for members funds will maintain a log of all

expenditures for each member.

F. All non-personal spending money disbursed from the member's account for any good(s) or service(s) will be verified within 30 days, by an itemized receipt. The receipt must show:

1. The merchant name(s)

2. Receipt Date

3. Receipt amount

4. A description of the item(s) purchased, or services delivered.

G. Until the properly supported receipt form is submitted, no further requests for that vendor or individual will be processed unless specifically approved by the Support Coordination District Program Administrator or Manager or designee.

H. It is permissible for a request to designate that several disbursements be made in the name of a member over a period. Examples include monthly personal allowances or rent subsidy. Such requests remain in effect until the Support Coordinator submits paperwork to change or cancel the request.

I. A disbursement request charging a member's account will not be honored unless that account has sufficient funds to pay the entire amount requested. The requesting party will be so notified, and a modified request can be submitted.

J. All requests will be processed by the payment deadline set by the district business office or designated member fund system personnel.

4004 – H MEMBER FUNDS – PROVIDER RESPONSIBILITIES

REVISION DATE: 12/16/2020, 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: Operations Policy Manual, 4004-I, Ledgers Maintained by Providers

Provider Responsibility for Member Funds

Qualified Vendor, Independent Provider, or Individual/Guardian must:

A. Provide services and care for a member, may request to receive and maintain funds from the Division of Developmental Disabilities (DDD, the Division) on behalf of the member, for personal spending and other uses. These funds must be recorded in a ledger (Refer to the *Operations Policy Manual, Chapter 4004-I Ledgers Maintained by Providers)* maintained in the member's residence or at the provider or agency's business office.

1. When there is an opportunity to request a one-time allocation of funds for the member to be used for a specific purchase or activity, this funding is in addition to the member's ongoing monthly spending funds and must be requested *from DDD Support Coordinator* and pre-approved.

2. For a reimbursement submission, use the *Expenditure Reconciliation (DDD-1832A)* form for all special funding requests for a one-time purchase or expense.

B. Provide a record of all member-designated funds received and proof of how they were spent to be fully approved and advanced by the Division.

C. Provide services and care for a member may request to receive and maintain funds from the Division of Developmental Disabilities (DDD, the Division), on behalf of the member, for personal spending and other uses. These funds must be recorded in a ledger (Refer to *Operations Policy Manual, Chapter 4004-I*) maintained in the member's residence or at the provider or agency's business office.

When there is an opportunity to request a one-time allocation of funds for the member to be used for a specific purchase or activity, this funding is in addition to the member's ongoing monthly spending funds and must be requested from the Division and pre-approved. A special funding request for a one-time purchase or expense must be submitted for reimbursement using the *Expenditure Reconciliation (DDD-1832A)* form.

D. Provide a record of all member-designated funds received and proof of how they were spent, to be fully approved and advanced by the Division.

Proper Use of Member Funds

A. Member special funds requests are for **member use only unless** written approval has been granted by the Social Security Administration (SSA). The use of member funds to pay the expenses of another person(s) to assist in a specific task, i.e., accompany the member to a destination for an activity where they will require care

and supervision but will be able to participate. If SSA has given their approval, it will be noted on the *Expenditure Reconciliation (DDD-1832A)* form.

B. Monthly ongoing spending funds do NOT have SSA approval and should never be used to pay for another person's expenses.

Valid Receipts

A. A legible receipt of the expense is required. The receipt must not be altered in any way; all the information on the receipt must be printed and legible.

B. Detailed notes of the expense are required, including merchant name, date, total expense, and a description of the items purchased or a reason for the expense.

Limitations

The following Member special fund disbursements are prohibited from the following:

A. To loan, borrow, give, or provide to any person, for any reason, other than the reason described in the original request, this includes to other members, provider staff, relatives, or friends.

B. Purchase anything that is ordinarily required to be supplied by the Qualified Vendor, Independent Provider, Individual/Guardian, or the Division.

C. For unauthorized purchases, the Division requires the Support Coordinator to provide written approval for amendments to the currently authorized expenditure.

D. To exceed the amount advanced of funds. The Division requires the Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

The Qualified Vendor, Independent Provider, or Individual/Guardian are prohibited from the following:

A. Establishing, assist in the application process, be included in the application process, or otherwise obtaining a credit card in the member's name.

B. Establishing, assist in the application process, be included in the application process, or otherwise obtaining a bank account or joint bank account for a member

- Exception: The following is required when opening a bank account as a habilitation goal for the member to become his or her own payee:
    - An outline of the goal, with a timeline in the member's planning document.
    - A review of monthly bank statements submitted to DES/DDD Member Funds Systems office.

- Close supervision of the member's bank account and funds in the DES/DDD account to ensure that the funds in, if combined, do not create an overpayment of resources.

C. Allows the member any direct access to the special funds received and maintained on behalf of the member.

D. Altered receipts will not be accepted, and the amount of the altered receipt will be refunded back to the member's DES/DDD member account. The provider will not be reimbursed for the expense.

Reporting the Use of All Funds Advanced by the Division

Upon receiving a special funds disbursement, advanced by the Division, the Qualified Vendor, Independent Provider, or Individual/Guardian must submit the required documentation to the Member Funds Systems office, within 30 days from the issue date of the check, as follows:

A. Purchases that were made on-line will contain the following:

1. The confirmation order shows merchant names, items purchased, item amount, date ordered, and total amount paid.

2. The confirmation form is showing the delivered date.

   Note: If a gift card was purchased with a special fund's disbursement, and the gift card was used to purchase items on-line, also provide a legible receipt for the gift card's purchase.

3. *Expenditure Reconciliation (DDD 1832A)* form

4. All excess funds must be returned to member funds in the form of a cashier's check, money order, or Qualified Vendor business check and submitted to the DES/DDD Member Funds Systems office.

B. Purchases that were not made on-line will contain the following:

1. Legible receipts that show merchant name, items purchased, item amount, date ordered, and total amount paid.

   Note: If a gift card was purchased with a special fund's disbursement, also provide the receipt for the purchase of the gift card.

2. *Expenditure Reconciliation (DDD 1832A)* form.

3. All excess funds must be returned to member funds in the form of a cashier's check, money order, or Qualified Vendor business check and submitted to the DES/DDD Member Funds Systems office.

Reimbursement for Expenditures in Excess of Advanced Funds

To request reimbursement for expenditures not covered by the original advanced funds, submit the following documentation to the Member Funds Systems office:

A. Purchases that were made on-line will contain the following:

1. The confirmation page or receipt of the order showing merchant name, items purchased, item amount, date ordered, and total amount paid.

2. The confirmation page is showing the delivered date.

   Note: If a gift card was used to purchase items on-line, also provide a legible receipt for the purchase of the gift card.

3. *Expenditure Reconciliation (DDD 1832A)* form

4. Written approval from the Support Coordinator.

   Note: Member funds are only used for authorized expenditures. The Division requires the Division Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

B. Purchases that were not made on-line will contain the following:

1. Legible receipts that show merchant name, items purchased, item amount, date purchased, and total amount paid

   Note: If a gift card was purchased with the funds, also provide original receipts for the purchase of the gift card.

2. *Expenditure Reconciliation (DDD 1832A* form).

3. Written approval from the Support Coordinator.

   Note: Member funds are only used for authorized expenditures. The Division requires the Division Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

Gift Card Purchases

A. The purchase of a gift card requires the same accounting practices and oversight as a cash purchase. Original receipts for the purchase of the gift card and detailed receipts showing the use of the gift card are required. The Individual or Qualified Vendor must submit the required documentation to the Member Funds Systems office within 30 days from the date on which the Division issued the check, per the reporting requirement.

   A gift card has been purchased for a family/friend, only the original receipt for the purchase of the gift card is required.

B. The purchase of a gift card for use by the member requires the same accounting practices and oversight as a cash purchase. The Qualified Vendor, Independent Provider, or Individual/Guardian must submit the required documentation to the Member Funds Systems office within 30 days from the issue date of the check, per the reporting requirement. If the gift card is not used within the 30-day timeframe, then the gift card should be returned to the Division and the funds refunded to the member's account. A new gift card can be requested and used at a later date, within a new 30-day timeframe.

C. If a gift card has been purchased for a family member or friend, only the original receipt for the purchase of the gift card is required to be reported to the Division. The family member or friend is not required to use the gift card within a specific timeframe and is not required to produce a receipt to verify how they spent the gift card.

4004-I LEDGERS MAINTAINED BY PROVIDERS

REVISION DATE: 2/24/2021, 12/2/2020, 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 41-1345, SSA Guide for Organizational Representative Payees, Publication No. 17-013

Purpose

The purpose of this policy is to establish the requirements for maintaining ledgers of funds for Division of Developmental Disabilities (the Division) members.

A Qualified Vendor, Independent Provider, or Individual/Guardian who receives funds from the Division of Developmental Disabilities (the Division), family, employment, or other sources, on behalf of the member, is required to open and maintain a separate ledger for each member receiving these funds. The ledger is a financial record, composed of a separate sub-ledger recording all the transactions with a daily balance. The monthly ending balance must not exceed $200.00 for each member. The Qualified Vendor, Independent Provider, or Individual/Guardian is required to return funds in excess of $200.00 to the DES/DDD Member Funds Systems office for depositing back into the member's account.

The Division recommends using the following form – *Member Funds Monthly Ledger (DDD-2036A),* refer to the *Documents Center* in the Division's intranet.

Ledgers

A. The Qualified Vendor, Independent Provider, or Individual/Guardian must account for **all** funds received and spent in the ledger. The format of the ledger must include:

1. The member's full name
2. The reporting month and year
3. The name of the Qualified Vendor, Independent Provider, or Individual/Guardian submitting the ledger.
4. The beginning or rolled over balance from the previous month; (a "running All balance").
5. The merchants name
6. All funds received: Source(s) of the fund(s) and the date(s) received
7. Expenditures: Memos on what was purchased, date(s), and receipt(s).
8. Receipts must be legible and include the merchant's name, date of purchase, the total amount of purchase, and description of items purchased. If receipts are not available, the cost must be identified on the monthly ledger and may be subject to additional scrutiny based on the amount and circumstances.

B. Ledgers should not have negative amounts listed.

C. Ledgers must be maintained for a minimum of six years. The Qualified Vendor, Independent Provider, or Individual/Guardian must:

1. Submit a **monthly ledger,** receipts, and excess funds to the DES/DDD Member Funds Systems office by the 15th of each following month.

   Note: The member's monthly spending funds will be *suspended* if the monthly ledgers, receipts, and excess funds are not submitted by the 15th of each following month. (Refer to Calendar.)

Calendar	
At the end of the month:	Submit the ledger by:
January	February 15th
February	March 15th
March	April 16th
April	May 15th
May	June 15th
June	July 15th
July	August 15th
August	September 15th
September	October 15th
October	November 15th
November	December 15th
December	January 15th

2. Provide the ledger for review at each Planning Meeting or as requested by the Division, the member, or the responsible person.

3. Ensure that the member's monthly spending funds are used to meet acceptable day-to-day personal needs as agreed in the planning documents, including recreation and miscellaneous expenses as required by the Social Security Administration.

4. Ensure that the member's funds are not used to purchase items required to be supplied by the Qualified Vendor, Independent Provider, Individual/Guardian, or the Division.

a. Transportation for daily activities, including but not limited to day treatment, employment preparedness, and training, employment, medical appointments, visits with family and/or friends, and community activities.

Room and Board, including three meals daily and snacks and/or as per service specification, for residential services including group homes and developmental homes.

5. Keep member funds in a secure locked location.

6. Not allow the member to have direct access to funds.

7. Ensure that the monthly ledgers are closed, the receipts and unspent funds are returned, and any required documentation is submitted to the DES/DDD Member Funds Systems office within 15 days from the date a member returns home, is no longer receiving services, or is deceased.

D. The Support Coordinator will adjust the spending plan to ensure that the member funds maintained by the Qualified Vendor, Independent Provider, or Individual/Guardian do not exceed the balances outlined above. Any excess funds must be returned to the Member Funds System for deposit into the member's account.

Missing Funds

A. If any funds are discovered stolen or missing from the member's ledger or personal cash, the Qualified Vendor, Independent Provider, or Individual/Guardian must:

1. Report to the Division:

a. By the close of the next business day following the discovery of the loss or theft.

b. Member funds, balances, and ledgers are subject to audit. Any audit exceptions are the responsibility of the service provider for resolution and/or repayment.

2. Replace the funds within ten (10) working days of the discovery of the theft or missing funds.

B. The Statewide Member Fund Manager and/or District Program Manager will determine whether it is appropriate to refer issues to the Department of Economic Security (DES), Office of Special Investigations (OSI), and the Social Security Administration (SSA).

Missing Ledgers

A. If a ledger is discovered missing, the funds issued for that month including, any rolled over funds recorded from the previous month, must be returned within 15 days of discovery.

4004-J BANK RECONCILIATION

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Bank and checkbook balances shall be reconciled monthly. The duties of reconciling the bank and Member Fund System balances and maintaining the accounting records will be separated. Bank, petty cash, and change fund balances shall be reconciled in member accounts monthly.

The Member Funds System Manager or designee shall send Monthly Member Fund reconciliation reports to the Division of Business and Finance, Accounting Office.

Summaries of these reports are to be sent to the Business Operations Administrator.

A report on the number of Title XIX eligible individuals shall be sent monthly to local Arizona Health Care Cost Containment System (AHCCCS) office:

A. Those with balances over $1,500; and,

B. Those with balances over $2,000.

A report including all accounts with balances over $2,000 shall be sent to the District Program Administrator/Manager. This report shall be reviewed by management staff to ensure that District staff are working towards a spend down plan.

4004-K ADMINISTRATION OF MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-1204; DDD Operations Policy 4004-O

The Division of Developmental Disabilities (The Division, DDD) administers member funds in accordance with the intent of the individual or entity providing the funds.

A. For the economy and efficiency of administration, member funds are pooled into one bank account. Separate records are maintained that identify each member's funds. Separate records are maintained which identify all transactions and balances for each member's individual Member funds account.

B. Funds in the pooled bank account in excess of current requirements must be invested following the provisions of the Division's Policy Manuals.

C. Unless allowed by law, member funds, including interest earnings, are not used to pay the cost of administration, supplies, equipment, or services. However, bank and investment institution service charges for administering pooled checking and investment accounts may be offset against interest earnings.

D. Member funds must not be loaned to other members, state employees, or any other agency or person.

E. Member funds that are advanced by the Division must be reconciled against receipts for all expenditures

F. Member One Time Special Funds that are advanced by the Division must be submitted with original receipts within 30 days from the check's issue date.

G. Any expenditure in excess of the original funds advanced must be evidenced by an original receipt and written prior approval from the DDD Support Coordinator to be eligible for reimbursement.

H. Member funds are only used for authorized expenditures. DDD Support Coordinator written approval is required for any amendment to the currently authorized expenditure.

I. All unspent member funds that have been advanced to a third party for purchases or allowances will be returned to the Client Fund System office, deposited into the bank, and credited to the appropriate member's account.

J. Money is paid out of the Division-administered member accounts only under the supervision of the DDD Support Coordinator. Supervisory approval is required for dollar amounts over $500.00. Client Fund System disbursements require a completed *Request for Funds (DDD-1833A)* submitted to the Member funds Unit

K. The use of a credit card must not be approved.

L. The purchase of gift cards requires the same accounting practices, oversight, and original receipts turned within 30 days of issuance of funds just as if issued by check.

M. Upon Social Security's approval (via a *Social Security Appraisal/Request for Funds (DDD-1823A*)form, member funds may be used to pay for the extraordinary expenses of an escort or attendant when the member is traveling, on vacation, or participating in community activities.

1. These expenses may include the cost of transportation, admission fees, meals, and lodging.

2. Non Covered Expenses are Snacks, alcoholic beverages, and souvenirs, or other personal purchases for the escort or attendant.

Prior to any disbursement of funds, a *Social Security Appraisal/Request for Funds (DDD-1823A)* is completed by the Support Coordinator and submitted to the Client Fund System office for Social Security approval. Upon Social Security's approval (via a *Social Security Appraisal/Request for Funds (DDD-1823A*)) form, member funds may be used to pay for an escort/attendant's extraordinary expenses member is traveling, on vacation, or participating in community activities.

Covered expenses may include

- The cost of transportation, admission fees, meals, and/or lodging
- Tipping is permitted with meals. The tip amount must be included on the receipt and come to no more than 20% of the bill. If the member is splitting the cost of a group meal, then the contribution to the tip should be divided equally among the number of persons sharing the meal. The total tip must be no more than 20% of the bill.
- Non-Covered expenses may include snacks, alcoholic beverages, and souvenirs, or other personal purchases for the escort or attendant.

N. Funds belonging to members who no longer require financial management from the Division must be disposed of as noted in *the Division's Operations Policy 4004-O, Termination of a Member's Account*.

4004 - M CHANGES IN MEMBER STATUS

REVISION DATE: 09/30/2020; 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. If a member, whose funds are managed by the Division of Developmental Disabilities (the Division), experiences any change in status, the Support Coordinator (SC) or the designee notifies Member Funds staff, who reports all changes to Social Security directly.

1. Changes in status include:

a. The member passes away

b. The member moves

c. The member marries

d. The member starts or stops working, even if the earnings are small.

e. A member's condition improves

f. The member starts receiving another government benefit or the amount of that benefit changes.

g. The member plans to leave the United States for 30 days or more

h. The member is imprisoned for a crime that carries a sentence of over one month.

i. The member is committed to an institution by court order for a crime committed because of mental impairment.

j. Custody of a child changes or a child is adopted

k. A child’s parent’s divorce

l. The Representative Payee can no longer serve as the Representative Payee, or; the member no longer needs a Representative Payee.

B. Additional events which must be reported by the SC to the Member Funds Systems Office for Supplemental Security Income (SSI) beneficiaries include:

1. The member moves in to or is released from a hospital, nursing home, or other institution; or is relocated from one location to another.

2. A married member separates from his or her spouse, or they begin living together after a separation.

3. Somebody moves into, or out of, the member's household.

4. The member has any change in income or resources (a child's SSI benefit check may change if there are any changes in the family income or resources).

4004-N INVESTING MEMBER FUNDS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Interest earnings, minus any bank charges on Member funds that are invested in the State Treasurer's Office, will be apportioned to member's accounts quarterly based on account period ending balances.

4004-O TERMINATION OF A MEMBER'S ACCOUNT OR CHANGE IN REPRESENTATIVE PAYEE

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887

Member Funds and the Death of a Member

When the Division of Developmental Disabilities (the Division) is notified that a member is deceased:

A. Benefits not payable must be returned to Social Security.

1. Social Security benefits are paid each month, representing payment for the previous month. When a person who receives social security benefits dies, no payment is due for the month of death, even if he or she dies on the last day of the month.

   Example: May 3rd SSA benefits are received April benefits, not May. If the member passes away in April, the benefit for April received in May must be returned to Social Security. The member is not entitled to a payment for the month of death.

2. Supplement Security Income (SSI) benefits are for the month in which they are paid. Therefore, the SSI benefit is paid for the month of death. SSI benefits received for months after the month of death must be returned.

   Example: May 1st SSI benefit is received, and the member died May 25 the SSI is retained. Suppose an SSI payment is received on June 1st that must be returned to Social Security.

B. All outstanding debts will be paid as the fund balance allows, including residential billing in accordance with the applicable rule and law.

C. Burial expenses may be paid as the fund balance allows.

D. Remaining fund balances are returned to the legal representative of a member's estate for disposition under state law.

   When there is no entity to receive money from the member's account, and there is no family, guardian, custodian, executor, or beneficiary, the following Arizona Revised Statutes will apply in the disbursement of the account: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887.

Social Security Selected a New Representative Payee

When the designated Representative Payee changes from the Division to another entity, all debts incurred while the Division was the Representative Payee must be paid, and all member funds identified as Social Security Benefits must be returned to the SSA. The

new Representative Payee may then request these funds from the SSA. The funds are not to be transferred directly from the Division to the new Representative Payee.

Inactive Accounts

Accounts determined to be inactive (having no transactions for a year or more) will be terminated after reasonable efforts to dispense the funds have failed. The account will be closed, and funds sent to the Arizona State Revenue after five (5) years, if unclaimed. (Unclaimed Property – Arizona Department of Revenue, Unclaimed Property Unit.)

If no one else is available, the Division may request to become the representative payee. Or, Social Security may request/require the Division to become the representative payee. A Member Fund System account is set up in the local district Business Office.

The Social Security Administration is to be notified of the change of address to the local Business Office for the District.

5000 REINSURANCE POLICY

REVISION DATE: 11/8/2023
EFFECTIVE DATE: 8/11/2021
REFERENCES: 42 U.S.C. § 1396b (i); 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 441.35; 42 C.F.R. § 433.135 et seq.; A.R.S. § 36-2903; A.R.S. § 8-512; Title XIX/XXI; A.A.C. R9-22-1001; A.A.C. R9-22-720; AHCCCS Reinsurance Manual; AHCCCS Contract; ISA DD-THP; ACOM 414; AMPM 1620-I; AMPM 310-DD; AMPM 300-2A; AdSS Operations Manual, Policy 414; DDD Operations Policy Manual 414; AdSS Medical Policy Manual 310-DD; DDD Medical Policy Manual 310-DD

PURPOSE

The purpose of this policy is to outline the requirements the Division must meet to request Reinsurance reimbursement from the Arizona Health Care Cost Containment System (AHCCCS).

DEFINITIONS

1. "Adjudicated Claim" means a claim that has been received and processed by the AdSS which resulted in payment or denial of payment.
2. "Behavioral Health Services" or "BHS" means physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

3. "Biologic Drugs" means products produced by biotechnology. These drugs are referred to as biologicals, biologic drugs, biological drugs, or biopharmaceuticals.
4. "Case" means a record for a Member that is composed of one or more Adjudicated Encounters.
5. "Case Type" means a description of the type of Reinsurance being paid to the Division based on the Member's medical condition and eligibility. Case Types include, but are not limited to DES, Hemophilia, von Willebrand Disease, Gaucher's Disease, Biologic or high cost specialty drugs, transplants, and High Cost Behavioral Health Services.
6. "Catastrophic Reinsurance" means reimbursement, full or partial, depending on the Case Type, from AHCCCS to the Division for the cost of care associated with certain medical conditions and specific drugs described in the Contract, AMPM, and DDD policy.
7. "Clean Claim Status" or "Clean Encounter" means a claim or Encounter that may be processed in the AHCCCS Prepaid Medical Management Information System (PMMIS) without obtaining additional information from the Contractor of service or from a third party; and has passed all of the Encounter and Reinsurance edits within the 15-month timely

filing deadline. This does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

8. "Coinsurance" means the percentage rate, established each Contract Year by AHCCCS, at which AHCCCS will reimburse the Division for covered services incurred above the Deductible.
9. "Contract" means, for the purposes of this policy, the legal written agreement that the Division has with AHCCCS for providing health care coverage to Members who are eligible for ALTCS. This coverage includes physical health services and Behavioral Health Services.
10. "Contractor" or "Division" for the purposes of this policy, means an organization or entity that has a prepaid capitated Contract with AHCCCS to provide goods and services to Members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and Federal law, and regulations.
11. "Contract Year" means the twelve-month period beginning on October 1st through and including September 30th for Reinsurance. The Contract Year may not correspond with the term of a Contract as specified in Section A of an entity's Contract with AHCCCS.

12. "Deductible" means the annual amount, established each Contract Year by AHCCCS, of Reinsurance covered services that must be paid and encountered by the Division for each individual Member before the Division receives Reinsurance payments from AHCCCS.
13. "DES Case Type" means certain covered inpatient facility services as described in the Contract, AMPM, and this policy that may qualify for Reinsurance reimbursement.
14. "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" means covered services for Members under 21 to correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act (Federal Law Subsection 42 USC 1396d (a)). Services are covered under EPSDT even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.
15. "Encounter" means a record of health care related service that is a mirror image of a claim and is rendered by a provider or providers

registered with AHCCCS to a Member who is enrolled with the Division on the date of service.

16. "Gaucher's Disease" means an inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
17. "Hemophilia" means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of Hemophilia - A, B, and C. The severity of Hemophilia is related to the amount of clotting factor in the blood.
18. "High Cost Behavioral Health" or "BEH" means specialized mental health services for ALTCS Members that were discontinued under Catastrophic Reinsurance, unless the Member was approved prior to October 1, 2007 and was active on September 30, 2007.
19. "Member" means the same as "client" as defined in A.R.S. § 36-551.
20. "Prepaid Medical Management Information System" or "PMMIS" means the AHCCCS mainframe pricing system of record that the Division uses for accessing the Reinsurance System.

21. "Prior Period Coverage" or "PPC" means the period of time prior to the Member's enrollment, during which a Member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a Member is enrolled with the Division.
22. "Prospective Coverage" means the period of time from when the AdSS receives notification the Member has been assigned to their plan and is expected to be capitated for the Member.
23. "Regular Reinsurance" means a partial reimbursement from AHCCCS to the Division for covered inpatient facility services (DES Case Type) as described in the Contract, AMPM, and DDD policy.
24. "Reinsurance" or "RI" means a stop-loss program provided by AHCCCS to the Division for the partial reimbursement of covered medical services incurred for a Member beyond an annual Deductible level.
25. "Reinsurance Payment Cycle" means the monthly updating of Reinsurance files in PMMIS for payment processing starting the first Wednesday of the month from 5:00 p.m. until the following Wednesday morning.
26. "Reinsurance System" means the PMMIS application for accessing Reinsurance Case data.

27. "Skilled Nursing Facility" or "SNF" means a nursing facility for those Members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.
28. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for AHCCCS benefits.
29. "Von Willebrand Disease" means an inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

POLICY

A. GENERAL REINSURANCE REIMBURSEMENT REQUIREMENTS FOR ALL CASE TYPES

1. The Division shall comply with the terms and conditions of the Contract with AHCCCS.
2. The Division shall require the Administrative Services Subcontractors (AdSS) to be responsible for the annual Deductible levels as determined by AHCCCS for covered medical services for each Member for the Contract Year.

3. The Division shall submit Reinsurance reimbursement requests from the AdSS to AHCCCS for Reinsurance covered services incurred for a Member beyond the annual Deductible level.
4. The Division shall require Encounters from the AdSS to meet the following criteria to qualify for Reinsurance reimbursement:
    a. The Encounter is approved and adjudicated within required time frames per the AHCCCS Contract and this policy;
    b. The Encounter associates to a Reinsurance Case;
    c. The Encounter is medically necessary;
    d. The service is non-experimental;
    e. The service is cost effective; and
    f. The service does not exceed an established cost threshold.
5. Upon receiving the Reinsurance funds from AHCCCS, the Division shall reimburse the AdSS the established AdSS Contract Coinsurance rate for Encounters that associate to a Reinsurance Case.
6. The Division shall not reimburse the AdSS for final Reinsurance claims which cross over Contract Years.

7. The Division shall base reimbursement of all covered Reinsurance Encounters on the following, unless costs are paid under a sub-capitated arrangement as outlined in subsection (8):
    a. Costs paid by the AdSS;
    b. Net of interest;
    c. Penalties;
    d. Discounts;
    e. AHCCCS Coinsurance rates;
    f. Medicare payment; and
    h. Third Party Liability (TPL) payment.
8. The Division shall base reimbursement of Reinsurance Encounters for costs paid under a sub-capitated arrangement on the following:
    a. The lower of the AHCCCS allowed amount;
    b. Reported AdSS paid amount;
    c. Net of interest;
    d. Penalties;
    e. Discounts;

f. AHCCCS Coinsurance rates;

g. Medicare payment; and

h. TPL payment.

9. The Division shall refer to the Reinsurance page on the AHCCCS website for current:

a. Deductible levels;

b. Coinsurance rates;

c. Eligibility requirements;

d. Documentation requirements;

e. Covered high cost or Biologic drugs;

f. Required time frames for submitting documentation and requests;

g. Reinsurance forms;

h. AHCCCS Reinsurance policy;

i. Transplant rates and Contracts; and

j. Reinsurance processing training manual and instructions.

10. The Division and the AdSS shall coordinate benefits with first party, Medicare, and TPL payers as required by Division Operations Policy Chapter 4001 and by the AHCCCS Contract.

11. The Division shall submit requests for Reinsurance reimbursement to AHCCCS by 5:00 p.m. if the due date lands on a business day; or by 5:00 p.m. the next business day, if the due date lands on a weekend or State-recognized holiday.
12. The Division may perform medical audits on Reinsurance Cases with advance notice to the AdSS.

B. REGULAR REINSURANCE (DES CASE TYPE) REQUIREMENTS

1. The Division shall request from AHCCCS partial reimbursement for the following Regular Reinsurance covered inpatient hospital services provided to Members:
    a. Acute care hospitals (provider type 02);
    b. Specialty per diem hospitals (provider type C4);
    c. Accredited psychiatric hospitals (provider type 71);
    d. Per diem rates for Skilled Nursing Facility (SNF) services provided within 30 days following an acute inpatient hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any Contract Year when:

i. The SNF stay is the first continuous SNF stay post inpatient discharge; or

ii. The second SNF admission follows an additional inpatient stay.

e. Services specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".

2. The Division shall not request Regular Reinsurance from AHCCCS for the following inpatient provider service types that are not covered by AHCCCS:

a. Same day admit-and-discharge services;

b. Mental health residential treatment centers;

c. Subacute facilities; and

d. Services that are not specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".

3. The Division shall pay Regular Reinsurance for the Member's Prospective Coverage and Prior Period Coverage (PPC) enrollment periods.

4. The Division shall reimburse the AdSS for Regular Reinsurance benefits once per month, subject to the availability of funds.

5. The Division shall follow the same requirements in this section for requesting Regular Reinsurance for Tribal Health Program (THP) claims.
6. The Division shall not pay Regular Reinsurance on the following types of claims:
    a. Final claims that cross over Contract Years; and
    b. Interim claims.
7. The Division shall request Regular Reinsurance consideration from AHCCCS for the final claim associated with the full length of a Member's hospital stay as long as the days of the hospital stay do not cross Contract Years.

C. GENERAL CATASTROPHIC REINSURANCE REQUIREMENTS

1. The Division shall request from AHCCCS partial reimbursement of Catastrophic Reinsurance for medically necessary covered services provided to Members for the following Case Types:
    a. Hemophilia;
    b. Von Willebrand Disease;
    c. Gaucher’s Disease;
    d. Biologic or high-cost specialty drugs;

e. High Cost Behavioral Health; and

f. Case Types other than transplants exceeding $1 million.

2. The Division shall not require Deductibles for Catastrophic Reinsurance Cases.

3. The Division shall request a new Catastrophic Reinsurance Case by submitting the following documents received from the AdSS to the AHCCCS Division of Health Care Management (DHCM) Medical Management Department (MM) within 30 days of the Member's initial diagnosis or enrollment with the Division:

   a. The Request for Catastrophic Reinsurance form; and

   b. Supporting clinical documentation.

4. The Division Health Care Services (HCS) shall review medical documentation submitted by the AdSS to confirm the Member's medical condition meets the criteria in Sections D, E, and F of this policy prior to submitting a request for a new Catastrophic Reinsurance Case to the AHCCCS MM.

5. The Division shall submit the following documentation received from the AdSS to the AHCCCS MM within 30 days of the start of

the Contract Year for continuation of previously approved Catastrophic Reinsurance Cases:

a. The Request for Catastrophic Reinsurance form; and

b. The Non-Transplant Catastrophic Reinsurance Member List form.

6. The Division may require supporting clinical documentation from the AdSS for previously approved Catastrophic Reinsurance.

7. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Catastrophic Reinsurance forms to the AdSS that submitted the request.

8. The Division shall utilize the AHCCCS Contract for Hemophilia factor and blood disorders as the authorizing payor.

9. The Division shall reimburse the AdSS for all medically necessary services provided during the Contract Year:

a. The current Coinsurance Rate for Catastrophic Cases; or

b. The AdSS’s paid amount, whichever is lower, depending on the subcap/CN1 code on the Encounter.

10. The Division shall reimburse the AdSS Catastrophic Reinsurance retroactively for a maximum of 30 days from the date the request is received by the AHCCCS MM.
11. The Division shall delegate prior authorization and care coordination to the AdSS for all components covered under the Contract for their Members.
12. The Division shall pay Reinsurance on catastrophic claims that contain any PPC and Prospective Coverage.

D. CATASTROPHIC REINSURANCE COVERAGE FOR BLOOD DISORDERS

1. The Division shall ensure Catastrophic Reinsurance coverage is available for all Members diagnosed with Hemophilia.
2. The Division shall base Catastrophic Reinsurance coverage for von Willebrand Disease on the following criteria:
    a. Type 1 and Type 2A that do not respond to desmopressin (DDAVP);
    b. Type 2B, Type 2M, and Type 2N based on diagnosis only; and
    c. Type 3 based on diagnosis only.

3. The Division shall base Catastrophic Reinsurance coverage for all Members diagnosed with Gaucher's Disease Type I.
4. The Division shall not request Catastrophic Reinsurance for Gaucher's Disease Type 2 and Type 3.

E. CATASTROPHIC REINSURANCE COVERAGE FOR BIOLOGIC OR HIGH-COST SPECIALTY DRUGS

1. The Division shall request Catastrophic Reinsurance from AHCCCS to cover the cost of medically necessary Biologic and high-cost specialty drugs for Members.
2. The Division shall request Catastrophic Reinsurance for the covered Biologic and high cost specialty drugs listed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website.
3. The Division shall reimburse Catastrophic Reinsurance to the AdSS as follows when a biosimilar or generic equivalent of a Biologic Drug is available, and is more cost effective than the brand-name product:
    a. The current Catastrophic Coinsurance rate of the lesser of the Biologic or high-cost or its biosimilar equivalent for

Reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific Member.

b. The current Catastrophic Coinsurance rate of the paid amount of the branded Biologic Drug if the AHCCCS Pharmacy and Therapeutics Committee mandates the utilization of only the brand name Biologic or high-cost specialty drug rather than the biosimilar.

4. The Division shall, in the instances in which AHCCCS has specialty Contracts, or when legislation and policy limits the allowable reimbursement, shall reimburse the Catastrophic Coinsurance rate of the lesser of:
   a. The AHCCCS contracted or mandated amount; or
   b. The AdSS's paid amount.
5. The Division may submit requests for new biological drugs or high-cost specialty drugs to the AHCCCS Reinsurance Unit for consideration for Reinsurance purposes.
6. The Division shall require the AdSS to encounter all Biologic or high-cost specialty drugs on a Form C pharmacy claim to be eligible for Reinsurance.

F. CATASTROPHIC REINSURANCE COVERAGE FOR HIGH COST BEHAVIORAL HEALTH

1. The Division shall request Catastrophic Reinsurance reimbursement from AHCCCS for medically necessary covered services provided during the Contract Year for Members enrolled in the High Cost Behavioral Health (BEH) Program prior to October 1, 2007.
2. The Division shall submit the following to the AHCCCS MM no later than 10 business days prior to the expiration of the current approval to request continuation of BEH Reinsurance Reimbursement:
    a. The High Cost Behavioral Health Reinsurance form, located in the AHCCCS website reauthorization request; and
    b. Supporting medical documentation as required in AMPM 1620-I.
3. The Division shall use Adjudicated Encounters for covered services provided to enrolled BEH Members to determine Reinsurance reimbursement.

4. The Division shall base Reinsurance coverage on documentation substantiating the Member's treatment is provided in the least restrictive treatment setting.

G. HIGH DOLLAR CATASTROPHIC REINSURANCE COVERAGE - $1,000,000+

1. The Division shall reimburse the AdSS 100% for all medically necessary Reinsurance covered expenses provided in a Contract Year for Case Types other than transplants, after the Reinsurance Case total value meets or exceeds $1 million, which is comprised of:
   a. The total AdSS paid amount; and
   b. The Deductible.
2. The Division shall require the AdSS to notify the Division once a Reinsurance Case total value reaches $1 million.
3. The Division, upon notification from the AdSS that a Reinsurance Case total value has reached $1 million, shall submit to AHCCCS:
   a. A Reinsurance Action Request form via the SFTP;
   b. A Catastrophic Case CRN Transfer Request form via the SFTP;

c. A request via email to the AHCCCS Reinsurance Supervisor and Reinsurance Analyst to create Case for the specific Case Type.

4. The Division shall disqualify the AdSS from receiving 100% reimbursement for Catastrophic Cases and related Encounters exceeding $1 million when the AdSS fails to do the following within 15 months of the end date of service:

a. Notify the Division of a Reinsurance Case reaching $1 million; or

b. Notify the AHCCCS Reinsurance Unit of Encounters that should be transferred; or

c. Adjudicate related Encounters.

H. CATASTROPHIC REINSURANCE COVERAGE FOR THP MEMBERS

1. The Division shall request Catastrophic Reinsurance reimbursement from AHCCCS for THP Members for the following Case Types:

a. Hemophilia;

b. Von Willebrand Disease;

c. Gaucher’s Disease;

d. Biologic or high-cost specialty drugs;

e. High Cost Behavioral Health; and

f. Case Types other than transplants exceeding $1 million.

2. The Division shall identify THP Cases eligible for Catastrophic Reinsurance reimbursement by data mining Encounters and claims information received weekly from AHCCCS and the AHCCCS pharmacy benefit manager.

3. The Division shall adhere to the general Catastrophic Reinsurance requirements listed in Section C of this policy for THP Members.

4. The Division shall use the same Case Type criteria for coverage of the medical conditions in Sections D, E, F, and G of this policy for THP Members.

J. TRANSPLANT REINSURANCE OVERVIEW

1. The Division shall request transplant Reinsurance from AHCCCS to partially reimburse the AdSS for the cost of care for enrolled Members:

a. Age 21 years and older who meet transplant Reinsurance coverage criteria for the specific transplant types listed AMPM 310-DD and the AHCCCS State Plan.

b. Under age 21, who under the EPSDT Program, are covered for all non-experimental transplants necessary to correct or ameliorate defects, illnesses, and physical conditions whether or not the particular non-experimental transplant is covered by the AHCCCS State Plan or listed in AMPM 310-DD.

2. The Division shall comply with the terms and conditions of the AHCCCS transplant specialty Contract.

3. The Division shall not require Deductibles for Transplant Reinsurance Cases.

4. The Division shall reimburse the AdSS the AHCCCS contracted Coinsurance rate for transplant services that qualify for Reinsurance.

5. The Division shall reimburse the AdSS the current AHCCCS contracted rates for the following transplant components:

a. Outpatient transplant evaluation;

b. Donor search and harvesting of the donor cells for stem cell transplants;

c. Preparation and transplant; and

d. Post-transplant care (Days 1 – 30 and Days 31 – 60).

6. The Division shall require the AdSS to notify the Division and AHCCCS when a Member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant.

7. The Division shall oversee the following responsibilities of the AdSS when the AHCCCS transplant specialty Contract is used:

a. Prior authorization; and

b. Care coordination.

K. TRANSPLANT CASE CREATION REQUIREMENTS

1. The Division shall require the AdSS to submit the Request for Transplant Reinsurance form to the Division within 30 days of the Member's first component of the transplant.

2. The Division HCS shall review all Requests for Transplant Reinsurance forms, supporting clinical documentation, and relevant AdSS policy received from the AdSS to confirm whether the transplant is:

a. Medically necessary;

b. Covered by AHCCCS;

c. Considered the standard of care; and

d. Not considered experimental.

3. The Division, upon determining the criteria are met in item 2 of this section, shall submit the Request for Transplant Reinsurance form received from the AdSS to the AHCCCS MM within 30 days of the Member's first component of the transplant to request approval and activation of the transplant Case in the PMMIS system for Reinsurance reimbursement.

4. If the Division receives a request for transplant Reinsurance that is outside the criteria in J(1)(a) of this policy, the Division may consult an independent review organization regarding whether a request for transplant Reinsurance is considered the standard of care and medically necessary.

5. If the Division determines the transplant should be authorized after receiving consultation from an independent review organization, the Division shall notify the AHCCCS MM of the

pending decision and submit the Request for Transplant Reinsurance form as required in item 1 of this section.

6. The Division shall submit to AHCCCS MM the Transplant Reinsurance Crossover Member List received from the AdSS for Members requiring continuation of previously approved transplant Reinsurance.
7. The Division shall refer to the Reinsurance Transplant Case Key Entry Instructions Manual on the AHCCCS website for transplant case management in the PMMIS system.
8. The Division may deny Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean Reinsurance claims; or
    b. Failure to submit the Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.
9. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Transplant Reinsurance forms to the AdSS that submitted the request.

L. REQUIRED TRANSPLANT CASE COMMUNICATION

1. The Division shall communicate the Division's transplant activity by submitting Quarterly Transplant Log form located on the AHCCCS website to the AHCCCS MM no later than 15 days after the end of each quarter as instructed in the AHCCCS Reinsurance Processing Manual.
2. The Division shall not alter or password protect the Quarterly Transplant Log format prior to submission to AHCCCS.
3. The Division shall submit the Quarterly Transplant Log with all the transplant activity from the previous Contract Year on or before October 15th of each year.
4. The Division shall remove all non-active Members from the Quarterly Transplant Log that is submitted for the new Contract Year on or prior to January 15th.
5. The Division shall only include transplant components that are reinsurable by AHCCCS on the Quarterly Transplant Log for the new Contract Year.

M. TRANSPLANT CLAIM REINSURANCE REIMBURSEMENT

1. The Division shall not reimburse the AdSS Regular Reinsurance if AHCCCS determines that a transplant is not eligible for transplant Reinsurance coverage.
2. The Division shall not reimburse the AdSS for the following transplants that are not eligible for transplant Reinsurance coverage:
    a. Bone graft transplants;
    b. Corneal transplants; and
    c. Kidney transplants.
3. The Division may submit to AHCCCS for consideration a request for Regular Reinsurance for transplants that do not qualify for transplant Reinsurance.
4. The Division shall not reimburse transplant Reinsurance for Members who have TPL including:
    a. Medicare Part A; or
    b. Medicare Parts A and B.

5. The Division may reimburse transplant Reinsurance, less any payments received from Medicare, for Members with Medicare coverage under the below circumstances:
    a. If the Member has Medicare Part A and has exhausted their Medicare Part A benefit including lifetime reserve days during a transplant stage, only that stage and subsequent stages may qualify for Reinsurance.
        i. If the Member chooses not to use their available lifetime reserve days, the transplant stages will not qualify for transplant Reinsurance.
    b. If the Member has Medicare Part B only.
    c. If the Member qualifies for partial transplant coverage, an explanation of benefits (EOB) with Medicare payments must:
        i. Balance with the Medicare payments in PMMIS; and
        ii. State that the Member has exhausted Medicare Part A.
6. The Division shall pay transplant Reinsurance reimbursement if Medicare does not cover a transplant type based on the

Member's diagnoses and the transplant type is an AHCCCS covered benefit.

7. The Division shall not apply quick pay discounts or interest to transplant Reinsurance reimbursements.
8. The Division shall retroactively reimburse transplant Reinsurance to the AdSS a maximum of 30 days from the date the Request for Transplant Reinsurance form was received and approved by AHCCCS.
9. The Division shall require the AdSS to submit clean Reinsurance claims to AHCCCS no later than 15 months from the end date of service for each transplant component in order to receive transplant Reinsurance reimbursement.
10. The Division shall recognize the submission date of Reinsurance claims to AHCCCS as the date of receipt by the AHCCCS Administration, DHCM Reinsurance Unit.
11. The Division may deny transplant Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean transplant Reinsurance claims; or

b. Failure to submit the Request for Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

12. The Division shall require the AdSS to file transplant Encounters with a CN1 code of 09 in order for the Encounter to associate to the transplant Case.

13. The Division shall require the AdSS to void and replace an incorrectly coded transplant Encounter with the correct CN1 code if there is more than 45 days before the 15-month timely filing deadline.

14. If there is less than 45 days before the 15-month timely transplant claim filing deadline, the Division may require the AdSS to:

    a. Submit a request to the AHCCCS Reinsurance analyst to manually associate transplant Encounters to the transplant Case; and

    b. Submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15-month timely filing deadline.

15. The Division shall only reimburse transplant Reinsurance for adjudicated Encounters that are associated with the transplant Case.
16. The Division shall reimburse Reinsurance for transplant stages when billed amounts and health plan paid amounts for adjudicated Encounters agree with supporting transplant claim and invoice amounts on the PMMIS RI115 screen.
17. The Division shall apply prorated calculations based on the number of days used in the stage only when:
    a. Tandem transplants occur; or
    b. A Member changes Health Plans, in the middle of a transplant stage.
18. The Division shall submit the following documentation received from the AdSS to the AHCCCS Reinsurance SFTP folder to request Reinsurance reimbursement for transplant stages:
    a. The Transplant Stage Invoice Cover Sheet; and
    b. The transplant checklist documentation requirements from the AHCCCS Reinsurance Processing Manual.

19. The Division shall calculate timeliness for each transplant stage payment based on the latest adjudication date for the complete set of Encounters related to the stage.
20. The Division shall notify AHCCCS by email that the information in item 18 a. - b. has been posted to the AHCCCS Reinsurance SFTP folder.

N. REQUIREMENTS FOR TRANSPLANTS THAT SPAN CONTRACT YEARS

1. The Division shall base the transplant stage Reimbursement rate on the end date of the stage.
2. The Division shall require the AdSS to split a transplant stage spanning two Contract Years based on the actual dates within the two Contract Years.
3. The Division shall not require the AdSS to split transplant Encounters spanning two Contract Years unless a transplant component exceeding 60 days exists.
4. The Division shall submit the Reinsurance Action Request Form received from the AdSS to the AHCCCS DHCM Reinsurance Unit

to request the transfer of transplant Encounter(s) spanning Contract Years to the Case based on the end date of the stage.

O. OUTLIER THRESHOLD COVERAGE FOR TRANSPLANTS

1. The Division shall pay the AdSS transplant outlier coverage upon AHCCCS approval of the AdSS's request for outlier coverage of a transplant Case.
2. The Division shall submit the following documentation received from the AdSS to the AHCCCS DHCM Reinsurance Unit to request consideration for transplant outlier coverage:
    a. Transplant Outlier Template form located on the AHCCCS website; and
    b. The documentation listed in the outlier checklist from the AHCCCS Reinsurance Processing Manual.

P. CLAIM ENCOUNTER DOCUMENTATION AND TIMEFRAMES FOR TRANSPLANT CONTRACTS

1. The Division shall submit adjudicated transplant claims for each stage of the solid organ transplantation or hematopoietic cellular therapy received from the AdSS to the AHCCCS DHCM

Reinsurance Unit no later than 15 months from the end date of service.

2. The Division shall consider adjudicated and payable transplant Encounters for the particular transplant stage completed on or before the 15-month timeframe, as a Clean Claim.
3. The Division shall require the AdSS to submit outlier claim components to the Division no later than 15 months from the end date of the last completed stage.
4. The Division shall submit the transplant Encounter file received from the AdSS to the AHCCCS DHCM Reinsurance Unit at least 45 days prior to the 15-month deadline to ensure that the adjudication meets the 15-month timeframe.
5. If the Division submits the Encounter file to AHCCCS less than 45 days before the 15-month timeframe and the adjudication has not been completed by the 15-month deadline, then the claim will be denied for not having achieved Clean Claim status within the required timeframe.

6. The Division shall base timeliness of the claim submission for each stage of the transplant on the submission date for the complete set of Encounters related to the stage.
7. The Division shall base timeliness for each transplant stage payment on the latest adjudication date for the complete set of Encounters related to the transplant stage.

Q. POST TRANSPLANT INPATIENT STAYS EXCEEDING 11 OR 61 DAYS

1. The Division shall apply the following requirements for continuous post-transplant inpatient care from the date of the prep and transplant component from day 11+ and for kidney transplants from day 61+ for all other Case Types:
   a. The Division shall reimburse the claim or Encounter for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other Case types for all Members at 75% of the transplant per diem rate less the Deductible.
   b. The Division shall pay outlier reimbursement when the cost threshold of the claim or Encounter for the continuous

inpatient stay for day 11+ for kidney transplants and day 61+ for all other Case Types is met or exceeded.

c. The Division shall ensure all day 11+ and day 61+ Encounters are received by AHCCCS prior to adjudication.

d. The Division shall split Encounters submitted for a day 11+ and day 61+ stage that spans Contract Years.

e. The Division shall refer to the AHCCCS website to access the Day 11+ or 61+ Transplant Component Worksheet and Instructions form.

2. The Division, using the Day 11+ or 61+ Outlier Worksheet and Instructions from the AHCCCS website, shall request from AHCCCS outlier reimbursement for transplant days 11+ and 61+ paid at the per diem rate pursuant to the AHCCCS transplant specialty Contract at an established cost threshold.

R. TRANSPLANT TRANSPORTATION AND LODGING REINSURANCE REIMBURSEMENT REQUIREMENTS

1. The Division shall reimburse Reinsurance for transportation, room, and board to the AdSS at the AHCCCS allowable rates for

the transplant candidate or recipient, potential donor or donor and, if needed, one adult caregiver.

2. The Division shall require the AdSS to submit a request to AHCCCS Reinsurance Finance using the Transplant Transportation Lodging form found on the AHCCCS website.

S. MULTI-ORGAN TRANSPLANTS THAT ARE NOT COVERED IN THE AHCCCS SPECIALTY CONTRACTS

1. The Division may request authorization from AHCCCS MM for transplant Cases that overlap when a second transplant component is started within the timeframe of an established component.
2. If a Member requires a multi-organ transplant, the Division shall request Reinsurance for the following:
   a. The preparation and transplant components for each organ when performed separately; and
   b. The post-transplant component that provides the AdSS with the highest reimbursement and covers the longest period of time.

c. The surgical component of the second transplant, if a second covered organ transplant is performed during the post-transplant periods of the first transplant.

3. If approved by AHCCCS, the Division shall reimburse prorated Reinsurance for the first transplant component and provide Reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1-30 post-transplant component and the day 31- 60 post-transplant component.

4. The Division shall follow all applicable notification and claims filing requirements when requesting authorization for Reinsurance reimbursement for multi-organ transplants that are not covered by AHCCCS.

T. MULTI-SEQUENCE TRANSPLANTS

1. The Division shall request authorization from AHCCCS MM for a transplant Case that requires an additional transplant for the same transplant type and an additional transplant sequence is started within the timeframe of an established component.

2. If a Member requires a second sequence transplant, the Division shall request Reinsurance for the initial transplant until the prep and transplant of the additional sequence occurs.
3. If an additional sequence is performed during the post-transplant periods of the previous transplant, the Division, upon approval from AHCCCS, shall reimburse the AdSS the prorated transplant component that coincides with the prep and transplant of the following sequence.
4. The Division shall follow all applicable AHCCCS notification and claims filing requirements when requesting Reinsurance reimbursement for multi-sequence transplants.

U. OUT OF STATE OR NON-CONTRACTED FACILITIES AND NON-CONTRACTED TRANSPLANTS

1. The Division shall, prior to the Member receiving out of state transplant services, require the AdSS to request approval for Reinsurance from AHCCCS if the transplant services are:
   a. At non-contracted transplant facilities; or
   b. At out-of-state contracted facilities for non-contracted transplant types.

2. The Division shall require the AdSS to obtain prior approval from the AHCCCS Medical Director for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service.
3. The AdSS shall, if prior approval is not obtained for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service:
    a. Incur costs for transplant services at the out of state facility;
    b. Be ineligible for either transplant or Regular Reinsurance; and
    c. Be ineligible for costs to be excluded from any applicable reconciliation calculations.
4. The Division shall, for an AHCCCS approved transplant performed out of state at a non-contracted facility, reimburse at 85% of the lesser of:
    a. The AHCCCS transplant contracted rate for the same organ or tissue, if available; or
    b. The AdSS paid amount.

5. The Division shall reimburse transplant Reinsurance depending on the unique circumstances of each AHCCCS approved non-contracted transplant, at 85% of the AdSS's paid amount for comparable Case or component rates.

V. SPLIT STAGES WHEN CONTRACTOR ENROLLMENT CHANGES

1. The Division shall require the AdSS to notify the Division when a Member changes AdSS during a transplant stage.
2. The Division shall edit the transplant stages in PMMIS for the dates of service each AdSS provided to the Member, when transplant stages are split between two AdSSs.

W. TRANSPLANT REINSURANCE REQUIREMENTS FOR THP MEMBERS

1. The Division shall submit the Request for Transplant Reinsurance form to the AHCCCS MM to create the transplant Case.
2. If the Request for Transplant Reinsurance is made by any entity other than the Division, the DDD Transplant Coordinator and DDD Reinsurance shall receive notification from AHCCCS MM.
3. The Division shall coordinate Transplant Reinsurance payment of claims and reimbursement with AHCCCS.

X. ENCOUNTER SUBMISSION REQUIREMENTS

1. The Division shall reimburse the AdSS for Reinsurance claims that correspond to Encounters that associate to a Reinsurance Case.
2. The Division shall require the following Reinsurance-associated Encounters except as provided for claim disputes, to reach an adjudicated status within 15 months from the end date of service, or date of eligibility posting, whichever is later to be considered as timely filed:
    a. Replacements;
    b. Voids; and
    c. New day Encounters
3. The AdSS shall not manually replace or void Encounters during the Reinsurance Payment Cycle.
4. The Division shall require the AdSS to void Encounters that are recouped in full.

Y. TIME LIMITS FOR FILING REINSURANCE CLAIMS

1. The Division shall pay the AdSS's Reinsurance claims for Regular Reinsurance Cases that are created automatically by PMMIS once

the Encounter reaches an adjudicated status through the Encounter System.

2. The Division shall require the AdSS to submit written requests for Reinsurance consideration for all other Reinsurance claims to the Division, except for Regular Reinsurance, using the required forms as described in this policy.
3. The Division shall require the AdSS to submit Encounters for Reinsurance that have attained a clean status no later than 15 months from the end date of service.
4. The Division shall require the AdSS to submit retro-eligibility Encounters that have attained a Clean Claim status no later than 15 months from the date of eligibility posting.
5. For Encounters undergoing Member appeal, provider claim dispute, grievance or other legal action, including an informal resolution originating from a request for a formal claim dispute or Member appeal, the Division shall consider the claim timely if:
    a. The decision letter is received by AHCCCS no later than 90 days from the date of the final decision in that action; and

b. The Encounters reach adjudicated status no later than 90 calendar days from the date of the final decision in that action, even if the 15-month deadline for attaining Clean Claim status has expired.

6. The Division shall not reimburse the AdSS Reinsurance if the AdSS fails to submit the adjudicated Encounter and the decision documentation within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director's decision, or other legal action, whichever is applicable.

Z. ADMINISTRATIVE DISPUTE REQUIREMENTS

The Division shall require the AdSS to follow the administrative dispute process as instructed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website, if the AdSS has exhausted Reinsurance refiling or reconsideration processes and still disagrees with an action taken regarding a Reinsurance claim.

AA. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

A. ENCOUNTER VOIDS AND REPLACEMENTS

1. When a void Encounter is submitted for a previously paid associated Reinsurance Encounter, the Reinsurance payment related to the voided Encounter will be recouped by AHCCCS.
2. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is less than the original AdSS paid amount, the difference will be recouped by AHCCCS.

3. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, the additional amount will be paid if the replacement Encounter was adjudicated and reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.
4. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, but the replacement Encounter was not adjudicated and did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same Encounter cycle, then the original AdSS paid amount will be recouped AHCCCS.
5. When a replacement Encounter is not submitted timely, and does not adjudicate to Encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of

eligibility posting, whichever is later, within the same Encounter cycle it was submitted, and any of the following scenarios occur:

a. The original Encounter was never associated to a Reinsurance Case; or

b. The original Encounter was never associated to a Reinsurance Case; or

c. The original Encounter associated with a Reinsurance Case but never reached pay status (PY); or

d. The original Encounter has a previous Reinsurance paid amount of zero ($0.00):

i. The replacement Encounter is then subject to the Reinsurance timely filing limit edits:

1) H583 Reinsurance claim received more than 15 months after end date of service; or

2) H584 Reinsurance claim received more than 15 months after eligibility posting.

6. When a Replacement Encounter is subject to the following scenarios:

a. Not submitted timely; and

b. Replacement Encounter did not adjudicate; and

c. Replacement Encounter did not reach approved status (CLM STAT 31); and

d. Within the same Encounter Cycle same Encounter cycle; and

e. Original Encounter (Encounter identified on the 837 & NCPDP) Reinsurance paid amount > $0:

i. The original AdSS paid amount will be recouped by AHCCCS.

7. The replacement Encounter consists of a two-step process:

a. The original AdSS paid amount will be recouped by AHCCCS.

b. The replacement Encounter transaction or process.

B. THIRD PARTY LIABILITY

1. Failure to comply with the TPL notification requirements may result in those sanctions specified in the AHCCCS Contract.

2. Should AHCCCS or its authorized representative identify TPL recovery payments received by the Contractors that do not

comply with the notification requirements in this section the following actions shall occur:

a. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.

b. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor's contingency fee schedule shall be added to the billing.

3. In addition, the Medicare Allowed, Medicare Paid, TPL Payments and Value Code fields, as applicable, must be completed when the Encounter is submitted for Reinsurance consideration.

C. MEDICARE

1. Medicare Calculations

a. The Reinsurance system does not calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data

is populated and mapped from the fields in the Encounter system.

b. If there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter, then the Contractor must address these issues with the AHCCCS Encounter Unit.

2. PMMIS' view of Medicare

a. The Encounter System categorizes Medicare as the type of Medicare appropriate for the stay. Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Part A dollars.

b. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Part B dollars.

c. Scenario Examples:

i. If the Member has only Medicare Part B and the Encounter is for an inpatient stay, then on the Encounter the Medicare Part B dollars should be placed under Other Coverage.

ii. If the Member has only Medicare Part B and the Encounter is for a doctor visit, then on the Encounter the Medicare Part B dollars should be placed under Medicare Coverage.

Form Type	Type of Medicare	Field on Encounter
I	Medicare Part A	Medicare
	Medicare Part B	Other Insurance
A	Medicare Part A	Does Not Apply
	Medicare Part B	Medicare
O	Medicare Part A	Other Insurance
	Medicare Part B	Does Not Apply

3. Medicare Lesser of Logic

   a. The Medicare copay, Coinsurance, or Deductible; or

   b. The difference between the Contractor's contracted rate and the Medicare paid amount.

4. Edit A510

   a. Medicare Deductible and Coinsurance Exceeds Allowed Amount

      i. Reinsurance Internal Pend

b. Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.

Summary of Reinsurance Coverage

Case Type	Deductible	Co-Ins
RAC-Acute Contractors	$75,000	75%
RAC-DCS/CHP Contractor	$75,000	75%
Catastrophic–Biologics/High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High$	n/a	100%
Hemophilia	n/a	85%
Von-Willebrand's	n/a	85%
Gaucher's	n/a	85%
State Only Termination	n/a	100%
High Cost Behavioral Health	n/a	75%
DES-DDD	$75,000	75%
RAC-ALTCS – EPD MC PT.A 0-1,999	$75,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	$75,000	75%
RAC-ALTCS – EPD No PT.A	$75,000	75%

0-1,999		
RAC-ALTCS – EPD No PT.A 2,000+	$75,000	75%

Reinsurance Contract Year	Contract Year Ending
YR 38	10/1/19 – 9/30/20
YR 39	10/1/20 – 9/30/21
YR 40	10/1/21 – 9/30/22
YR 41	10/1/22 – 9/30/23
YR 42	10/1/23 – 9/30/24
YR 43	10/1/24 – 9/30/25
YR 44	10/1/25 – 9/30/26

6001-A CONFIDENTIALITY

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-568(01), 36-551(07), 41-1346, 41-1959, 36-568(01), and, 36-551(01); A.A.C. R6-6-102, et seq., and, R6-6-102.

Confidential Information

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, Social Security Number (SSN), ASSISTS or Arizona Health Care Costs Containment System (AHCCCS) I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

A. The right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;

B. The right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;

C. The right to receive one copy of their medical record free of charge annually;

D. The right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;

E. The right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;

F. The right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;

G. Subpoenas are not court orders. Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F;

H. The right to file complaints;

I. The right to seek correction of records; and

J. Should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.

6001-B RELEASE OF INFORMATION

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-104; 42 CFR 483.410(c) (3).

An authorized list of persons or titles, who may have access to personally identifiable information, shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

A. Obtained from the member or responsible person in writing and dated); and,

B. Maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.

6001-C ACCESS TO PERSONALLY IDENTIFIABLE INFORMATION

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R6-6-103.

A *Record of Access* documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a *Record of Access* is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with ALL personally identifying information deleted.

While Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) do not require a standardized *Record of Access*, all *Record of Access* documents shall include:

A. Requestor's name;

B. Date information copied/sent;

C. Purpose for request;

D. Specific information released;

E. Where information was sent; and

F. Verification of consent.

A *Record of Access* is not required for the following:

A. Member/responsible person or their written designee;

B. Federally authorized members including AHCCCS and DHS staff; or

C. Direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must maintain a Log Book which documents the names of persons, other than Support Coordinators, or supervisors reviewing the case record and date/time of the review is maintained. The *Record of Access* is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the *Record of Access* (See Master Folder Access Log).

6001-E VIOLATIONS AND PENALTIES

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-204

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE'S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.

6001-F CASE RECORDS

REVISION DATE: 8/28/2019, 5/29/2019, 2/17/2017, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: 42 CFR 483.410(c)(1)(6)

Central Case Records

The Division of Developmental Disabilities (Division) maintains a central case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to a member and is kept in a location designated by the local Confidentiality Officer/designee, but it is usually in the Support Coordinator/Qualified Intellectual Disabilities Professional's (QIDP's) office.

Central case records are available to the member or responsible person upon written request to:

Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301
Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

The Support Coordinator makes sure that all information generated regarding services to the member is documented in the central case record.

A. Central case records must contain the following:

1. Birth Certificate
2. Guardianship records, if applicable
3. Adoption records, if applicable
4. Divorce Decree, and/or Custody Orders, if applicable
5. Court Orders [including Orders of Protection], if applicable
6. Arizona Confidentiality Program (ACP) records, if applicable
7. A copy of the member's Planning Documents/Individualized Education Program (IEP)
8. Program data and progress notes
9. The member's identifying information and a brief social history
10. Pertinent health/medical information
11. Current evaluative data/assessments
12. Authorization for emergency care, if appropriate

13. Visitation records, if appropriate
14. Record of financial disbursements, if appropriate
15. Active treatment schedule (ICF/IID)
16. Resident fact sheet, if appropriate
17. Periodic dental records, if appropriate
18. ICAP, if appropriate
19. Documentation regarding the protection of member rights, including records authorizing the release of educational and protected health information.
20. An accepted diagnosis/diagnostic scheme
21. Documentation of an evaluation that identifies the member's specific needs
22. Reviews/modifications to the Planning Documents and IEP
23. Communication among persons involved with the member and his/her program, including emails
24. Documentation of protection of the legal rights of each person served including records of all actions that may significantly affect these rights
25. Documentation to furnish a basis of review, study and evaluation of overall programs provided by the Division
26. Member primary data from FOCUS
27. For members residing in a Nursing Facility (NF) placed on termination status:
    a. A Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs
    b. Documentation of the member's choice of placement
    c. The reason for non-placement in a NF placed on termination status for a new placement.

B. Case records, where applicable, must contain the following additional documentation:

1. Arizona Long Term Care System (ALTCS) eligibility
2. Utilization review report
3. Current photograph of the member, if needed
4. Physician statements of medical necessity
5. Pre-Admission Screening
6. Psychological evaluations/social history

7. Medication history
8. Immunization record
9. Incident, injury, illness, and treatment reports including hospital stays
10. Seizure reports
11. Records of contacts/referrals
12. An accounting ledger
13. Authorization for emergency care
14. Behavioral health records as described in this Policy Manual
15. Other pertinent information.

Program/Service Records

Occasionally, the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records; this includes overflow files. The Confidentiality Officer, Support Coordinator, or QIDP assures:

- Files are available at each site where the member receives services, as appropriate
- The Support Coordinator/QIDP has access to such files
- A summary of information contained in such records is entered into the member's Central record.

These files must contain:

A. The name, address and phone number of the physician or health facility providing medical care
B. Reports of accidents, illness, and treatments
C. Reports of significant behavioral incidents, if applicable
D. Current medication treatment plan, if applicable
E. A description of the member's specialized needs
F. A copy of the Planning Documents/IEP
G. Program data/progress notes
H. Identifying information/social summary
I. Pertinent health/medical information
J. Current evaluative data/assessments

K. Authorization for emergency care

L. Visitation records

M. Records of financial disbursements

N. Active treatment schedule (ICF/IID)

O. Resident fact sheet; and where applicable

P. Periodic dental reports.

6001-H RECORDS STORAGE AND SECURITY

REVISION DATE: 2/17/2017, 12/11/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297, *Records Reference Request* (J-240)

Internal Storage (Active Case Records)

The Division of Developmental Disabilities (Division) considers case records for members currently eligible for services to be active records. Active files may contain too much information to be confined to one case record. The Division may establish and use overflow files to store non-essential, outdated information.

Once established, overflow records can contain progress notes, educational records, Planning Documents, correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, Qualified Intellectual Disabilities Professional (QIDP) notes in the most current active record that there is an overflow(s) file and indicate where it is stored.

The overflow record is maintained within the Division in a place designated by the District for an unspecified period of time.

External Storage (Closed/Terminated Case Records)

The Records Center is the Department of Economic Security (DES) official depository for closed/terminated case records. The Records Center provides storage, retrieval, and re-file services for DES.

To transfer closed/terminated files for storage/retention, Division staff:

A. Review the records retention schedule to determine that the records are appropriate for retention at this time.

B. Pack records into standard boxes 15” L X 12” W X 10” H, leaving a minimum of two inches of space to permit retrieval.

C. Electronically complete a *DES Records Storage Request* (J-239) through the Records Center Management System (RCMS).

D. Assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up.

E. Upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, Division staff electronically complete a *Records Reference Request* (J-240) through RCMS.

Destruction of Records

Records are destroyed in accordance with the records retention schedule, in compliance with A.R.S. § 12-2297.

6001-I MANAGEMENT AND MAINTENANCE OF RECORDS

REVISION DATE: 12/22/2021, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297,42 CFR 438.3(U)

POLICY

The Division of Developmental Disabilities (Division) must maintain all records for a period of five years from the date of final payment under contract with Arizona Health Care Cost Containment System (AHCCCS) unless a longer period of time is required by law.

For retention of the member's medical records, the Division must ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider must retain the member's medical records according to the following:

A. If the member is an adult, the Division must retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the Division.

B. If the member is under 18 years of age, the Division must maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division must comply with the record retention periods specified in HIPAA Privacy Rule and regulations.

If the Division's contract with AHCCCS is completely or partially terminated, the records relating to the work terminated must be preserved and made available for a period of five years from the date of any such termination.

Records that relate to grievances, disputes, litigation, or the settlement of claims arising out of the performance of the Division's contract with AHCCCS, or costs and expenses of the Division's contract with AHCCCS to which exception has been taken by AHCCCS, must be retained by the Division for a period of ten years after the date of final disposition or resolution thereof. [See 42 CFR 438.3(U)].

6001-J RECORDS MANAGEMENT LITIGATION HOLD

EFFECTIVE DATE: February 28, 2024

REFERENCES: A.R.S. § 38-421, A.R.S. § 39-121-.01, A.R.S. § 41-151.12, A.R.S. § 41-151.13, A.R.S. § 41-151.14, A.R.S. § 41-151.15, A.R.S. § 41-151.16, A.R.S. § 41-151, A.R.S. § 41-151.18, Arizona State Library, Archives and Public Records Schedule Numbers: DES-CS-1125 - 35132, 35131, 53310, and 53311

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. The purpose of this policy is to outline staff responsibility when there is a litigation hold Notice to Preserve.

DEFINITIONS

1. "Custodian of Records" or "Custodian" means any Division employee who manages records at the office level and is the base for implementing records management policies and procedures by applying a records-retention schedule.
2. "Disposition Schedule" or "Retention Schedule" means a list of record series titles that indicates the minimum length of time to

maintain each series and what should happen once the retention period has been met.

3. "Employee Tracking List" means a comprehensive list of Division employees who are or were associated with the coordination of care for a Member related to a litigation hold notice to preserve.
4. "Litigation Hold" means an internal process that an organization undergoes to preserve all data that might relate to a legal action involving the organization.
5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Notice to Preserve" means a letter or other notice informing an employee of actual or reasonably anticipated litigation, otherwise known as a pre-claim, and directing the employee or group of employees to identify, collect, and preserve relevant information.
7. "Records" means all hardcopy and electronic books, paper, emails, maps, photographs, drafts, markups, or other documentary materials, regardless of physical form or characteristics, including prints or copies of such items produced or reproduced on film or electronic media pursuant to A.R.S. §

41-151.16; made or received by any governmental agency in pursuance of law or in connection with the transaction of public business and preserved or appropriate for preservation by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the government, or because of the informational and historical value of the data contained therein, and includes records that are made confidential by statute. Library or museum material made or acquired solely for reference or exhibition purposes, extra copies of documents preserved only for convenience of reference and stocks of publications or documents intended for sale or distribution to interested persons are not included within the definition of records. All records media are included in this definition from the traditional paper forms to electronic types in use (i.e., email, social media), and/or forms of records not yet invented.

8. "Records Management Center" or "RMC" means the facility where DCS records are stored, retrieved, and eventually destroyed according to record retention schedules.

9. "Records Management Unit" or "RMU" means the Division's records department that maintains and oversees the management of Member records.

POLICY

A. The Division shall retain any record upon Notice to Preserve relevant to litigation as follows:

1. The Division shall retain relevant records:
    a. For six years after the prospect of litigation ends or according to the record disposition schedule for DES-CS-1125, whichever is later; and
    b. If there is no court action until the expiration of all time periods within which legal action may be taken.
2. Division employees having access to any records outlined in a Litigation Hold shall preserve all records in their original forms.
3. The Division shall prevent the destruction, alteration, or deletion of relevant information and records.
4. The Division shall preserve the following types of items for a Litigation hold:
    a. Emails;

b. Contact lists;

c. Text/chat messages;

d. Spreadsheets;

e. Presentations;

f. Databases, or other data stored;

g. Video, transcripts and audio recordings;

h. Medical documentation; and

i. Documentation of services, and anything else that can be electronically stored and is related to the litigation subject.

B. The RMU shall:

1. Gather all records related to the actual or anticipated litigation, including paper and electronically stored records, and
2. Review documents to identify Division staff names for the given time period outlined in the litigation hold;

C. The RMU shall preserve, catalog, and retain the related files within the Records Management Center:

1. The Custodian shall not remove, transfer, or destroy preserved records while the Litigation Hold is in place.

2. After the notice to preserve has been lifted, RMU staff shall adhere to the appropriate retention period ends.

6002-D MEMBERS AT RISK IF MISSING

REVISION DATE: 8/2/23, 3/16/22, 11/29/17, 5/20/16, 3/2/15 EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 46-451(A)(10), A.R.S. § 14-1501, A.R.S. §36-551, A.A.C. R6-6-805, Division Medical Policy 966

PURPOSE

To set forth the requirements of vendors and the Division of Developmental Disabilities' (Division) staff when a Member is missing and the subsequent review or revision of the Planning Document by the Planning Team.

DEFINITIONS

1. "Immediate Jeopardy" means a situation in which the vendor's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member(s). An Immediate Jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm. See Division Medical Policy 966.

2. “Medallion Program” means Members enrolled in this program receive a medallion that can be worn as a bracelet or shoe tag. This medallion provides identification that helps first responders in case of an emergency or if a Division Member becomes lost in the community. Each identification tag includes the Member’s Focus ID number and a 24-hour phone number for first response emergency personnel to contact.

3. “Media” means any type of electronic, digital, or print communication including newspapers, TV, radio, flyers, newsletters. or other internet-based forms of electronic communication such as websites for social networking, blogs.

4. “Member” means the same as “Client” as defined in A.R.S. § 36-551.

5. “Planning Document” means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP) or Person Centered Service Plan (PCSP).

6. “Planning Team” means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S § 36- 551.

8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. MISSING MEMBERS

1. If a Member without planned alone time, while receiving Division-authorized services, is missing or at is risk of harm, or when a Member with alone time as defined in the Planning Document is missing longer than the plan provides, including a Member missing from a licensed Behavioral Health Inpatient Facility (BHIF), Behavioral Health Residential Facility (BHRF), Division Group Home, Assisted Living Facility (ALF), Skilled Nursing Facility (SNF), Intermediate Care Facility, Adult Behavioral Health Therapeutic Home (ABHTH), or Therapeutic Foster Care (TFC), the vendor shall:

a. Conduct a search of the immediate area.

b. Notify the program supervisor or other staff to assist with the search if the Member is not located within 15 minutes.

c. Contact local hospitals, shelters, jails, and bus stations during the search.

d. If the Member is not located within 30 minutes the vendor shall notify law enforcement agencies in the immediate and surrounding communities and provide all relevant information, including medical conditions, medication, behavioral and communication needs.

3. The vendor shall immediately notify the following entities, document who was contacted, date and time, and send a confirmation email after notification is made:

a. The Division by calling the District specific Quality Assurance phone number, emailing the Incident Report Inbox, or calling the after-hours reporting system on evenings and weekends at 602-375-1403.

i. If a situation is determined to likely cause serious

injury, harm, impairment, or death to a Member(s), and an immediate need to be corrected to avoid further or future serious harm, indicate in the report that the situation may require an Immediate Jeopardy response.

b. Support Coordination during regular business hours or by calling the District after hours reporting system on evenings and weekends at (602) 375-1403 or provide the information in an email to the District specific Incident Report Inbox.

c. The guardian(s), if applicable.

4. The vendor shall report and submit a written incident report to the Division as soon as possible but no later than the next business day after the incident. The vendor may submit the incident report to the Division via fax or email using the District contact information.

5. The vendor shall include the following information in the incident report:

a. Age of Member

b. General description of the person

c. Time and location of disappearance

d. Effort to locate Member(s)

e. Vulnerability

f. Means of communication

g. Medical or special needs

h. Precursors to disappearance

i. Time police and parents or guardian notified

j. Time and person or method of Division notification

k. Other entities contacted

l. Legal status (e.g., foster care, probation).

6. The Support Coordinator shall, if the Member has prescribed medication, contact the physician or pharmacist to determine whether a potential medical risk may arise if the Member goes without prescribed medication for any length of time.

B. DIVISION RESPONSIBILITIES

1. The Support Coordinator shall convene the Planning Team within 30 days, or sooner as designated in the Planning Document, of

the date the Member was reported missing to:

a. Review the current Planning Document and Risk Assessment,

b. Modify the Planning Document as appropriate, and

c. Complete or update form DDD 1569A if the Member resides in a group home licensed by Arizona Department of Health Services consistent with A.A.C. R6-6-805.

C. MEDIA INVOLVEMENT

1. If law enforcement elects to contact the Media to assist in locating the Member, the vendor shall:

   a. Cooperate with law enforcement officials by providing essential information about the Member to be released to the Media,

   b. Notify the designated District Quality Assurance staff,

   c. Notify the designated support coordinator, and.

   d. Notify the parent(s) or guardian(s), if applicable.

2. The Division District Quality Assurance staff shall notify Executive Leadership via the Division's Executive Leadership

Notifications mailbox upon notification of Media involvement by the vendor.

Signature of Chief Medical Officer:

SUPPLEMENTAL INFORMATIONAL

1. Members who enroll in the Medallion Program agree to the disclosure of certain protected health information to rescuers in order to provide the Member with assistance in an emergency or if they are lost in the community.

2. The QMU staff answers the Medallion hotline during regular business hours and the Arizona Training Program at Coolidge staff answers the hotline calls after hours.

3. Upon receipt of a call, staff verifies that the caller obtained the phone number from the Medallion identification tag of the Member. Information may be disclosed to the caller, generally expected to be law enforcement, emergency medical providers, or individuals attempting to assist the Member, in the event the Member becomes ill, lost, injured or otherwise physically or

mentally impaired and needs assistance.

4. Protected health information which may be disclosed by staff includes address and applicable individual, parent or guardian contact information, and any health care information relating to the Member that staff determines is needed by the caller in order to provide appropriate medical treatment to the Member or to provide for the Member's safety and welfare until the Member's parent, guardian, or responsible party is able to resume custody of the Member.

5. Staff will not disclose protected health information to a caller who is not law enforcement or emergency medical providers, and contacts the Member's parent, guardian, or responsible party, and arrange for them to resume custody of the Member as soon as possible.

Signature of Chief Medical Officer: Anthony Dekker (Jul 31, 2023 15:16 PDT)
Anthony Dekker, D.O.

6002-F INVESTIGATIVE PROCESS

REVISION DATE: 11/8/23, 6/29/22, 12/18/19, 10/01/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: Division Medical Policy 960 and 961

PURPOSE

To set forth the requirements for investigative activities performed by the Division of Developmental Disabilities' (Division) Quality Management Unit (QMU) to gather and review information and documentation related to reported incidents involving Members served by the Division.

DEFINITIONS

1. "Investigative Process" means a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident.

2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

3. "Quality of Care Concern" means an allegation that any aspect of care or treatment, utilization of behavioral health services or utilization of physical health care services, that caused or could have caused an acute medical condition or acute psychiatric condition, or an exacerbation of a chronic medical condition or chronic psychiatric

condition, and may ultimately cause the risk of harm to a Member.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed as defined in A.R.S. §36-551.

5. "Trauma-Informed Care" means an approach to care that acknowledges the need to understand an individual's life experiences in order to deliver effective care and has the potential to improve engagement, treatment adherence, health outcomes, and provider and staff wellness.

6. "Sentinel Event" means an unexpected event that results in death, serious physical injury, or severe psychological harm.

POLICY

A. INVESTIGATIVE PROCESS AND TRAINING

1. The Division's QMU shall provide investigative training for QMU staff.

2. The QMU nursing leadership shall ensure that clinical staff

complete all required investigative training and achievement of competencies before conducting investigations independently.

3. The Division shall incorporate the principles of Trauma-Informed Care in the training content and requirements for investigations involving individuals with intellectual and developmental disabilities.

4. The Division shall maintain records of attendance and dates for all required investigative training.

B. INVESTIGATIVE PROCESS REQUIREMENTS AND TIMEFRAMES

1. The Division's QMU shall initiate the Investigative Process for all reportable incidents requiring further investigation and adhere to the following investigative requirements and timeframes:
   a. Upon notification of an incident determined to be a Quality of Care (QOC) Concern, initiate the Investigative Process within one business day.
   b. Assign a QMU investigative team to conduct the QOC Concern investigation.
   c. Ensure protective measures are in place to protect the health and safety of the Member or Members.

d. Ensure measures are in place to prevent any direct contact between the Member and any individual alleged to have endangered the health or safety of the Member until the completion of the investigation and any subsequent remediation.

e. Complete information requests for Sentinel Events within one business day.

f. Complete information requests for non-Sentinel Events within seven business days.

g. Information gathering may be completed for incidents determined not to be a QOC Concern as necessary and appropriate.

C. COORDINATION WITH OTHER AGENCIES

1. The QMU may delay its Investigative Process if an external investigation is initiated by a protective services agency, law enforcement agency, other state agencies or regulatory boards, until the external investigation has been completed in order to avoid potential conflicts.

2. If another state agency is involved, the QMU may coordinate

investigative activities with that agency when applicable and appropriate.

D. INVESTIGATIVE ACTIVITIES

1. The QMU shall include the following investigative activities in accordance with the principles of Trauma-Informed Care and the special needs of Members with intellectual and developmental disabilities:

    a. Collection and review of documentation, reports, and information relevant to the incident.

    b. Interview individuals involved in the incident and any witnesses, family members, qualified vendors, Division staff, first responders, or any other individual who may have relevant information.

    c. Allow the Responsible Person to decline an interview at any time during an investigation.

2. The QMU shall enter documentation of investigative activities in the AHCCCS Quality Management Portal.

3. The QMU shall store the compilation of collected information on a QMU shared drive and readily available to QMU staff on a

need-to-know basis containing:

a. The original incident report;

b. Completed District Assignment form; and

c. Information and documents gathered during the Investigative Process.

4. The QMU shall consider all information and documentation obtained during the Investigative Process as confidential and privileged for use in conducting quality assurance activities and use by Division review committees, as well as the information obtained through the Division's Investigative Process, inclusive of the determination and any remediation, is protected from release or discovery under the following Arizona Revised Statutes §§ 36-441, 36-445, 36-445.01, 36-2401 through 36-2404, 36-2917, 36-2932(O) and 41-1959(C)(5).

Signature of Chief Medical Officer: Anthony Dekker (Nov 2, 2023 08:14 PDT)
Anthony Dekker, D.O.

6002-G REPORTING MEMBER ABUSE, NEGLECT, AND EXPLOITATION

REVISION DATE: 6/14/23, 3/16/22, 9/4/19, 11/29/17, 10/1/14

EFFECTIVE DATE: July 31, 1993

REFERENCES: Title 13, Chapter 14, A.R.S. §§ 13-3620, 13-3401, 14-1501, 46-451(A), 46-454, 36-569, 8-201(2), Division Medical Policies 960, 961, 1620-O

PURPOSE

This policy applies to all Division of Developmental Disabilities (Division) staff and sets forth the responsibilities for reporting suspected Abuse, Neglect, and Exploitation of Members served by the Division to the Department of Child Safety (DCS) and Adult Protective Services (APS), and Tribal Social Services, when applicable, for Members enrolled in the Tribal Health Program.

DEFINITIONS

1. “Abuse” means the infliction of or allowing another individual to inflict or cause physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a

Member receiving behavioral health services or community services. Abuse also includes sexual misconduct, assault, molestation, incest, or prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

a. "Abuse of a Child" means, as specified in A.R.S. §8-201(2):

i. The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage, as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts of omissions of an individual who has the care, custody, and control of a child. Abuse includes:

ii. Inflicting or allowing sexual abuse, sexual conduct with a minor, sexual assault, molestation of a Child, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, or child sex trafficking as those acts are described in the Arizona Revised Statute Title 13, Chapter 14.

iii. Physical Injury that results from permitting a Child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in A.R.S. § 13-3401.

iv. Unreasonable confinement of a Child.

b. "Abuse of a Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(1):

i. Intentional infliction of physical harm,

ii. Injury caused by negligent acts or omissions,

iii. Unreasonable confinement,

iv. Sexual abuse or sexual assault.

2. "Adult" means a member 18 years of age or older.

3. "Child" means a Member under the age of 18 years.

4. "Exploitation of a Vulnerable Adult" means, as specified in A.R.S. § 46-451(A)(5), the illegal or improper use of a Vulnerable Adult or the Vulnerable Adult's resources for another's profit or advantage.

5. "Incapacity" means an impairment by reason of mental illness, mental

deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning their person.

6. "Member" means an individual enrolled with the Division of Developmental Disabilities.
7. "Neglect" means, as specified inA.R.S. § 36-569:
    a. Intentional lack of attention to physical needs of Members such as toileting, bathing, meals, and safety.
    b. Intentional failure to report health problems or changes in health condition to an immediate supervisor or nurse.
    c. Sleeping on duty or abandoning workstation.
    d. Intentional failure to carry out a prescribed treatment plan for a Member.
8. "Neglect of a Child" means, as specified in A.R.S. § 8-201:
    a. The inability or unwillingness of a parent, guardian, or custodian of a Child to provide that Child with supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk or harm to the Child's health or welfare, except if the inability of a parent, guardian, or custodian to provide

services to meet the needs of a Child with a disability or chronic illness is solely the result of unavailability of reasonable services.

b. Allowing a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person with the intent and for the purpose of manufacturing a dangerous drug as defined in section 13-3401.

9. "Neglect of a Vulnerable Adult" means, as specified in A.R.S. § 46-451(A)(7), the deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating, or other services necessary to maintain a vulnerable adult's minimum physical or mental health.

10. "Physical Injury" means the impairment of physical condition, including skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

11. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, including assessment or treatment in an emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

12. "Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(10), a Member who is 18 years of age or older who is unable to protect themselves from Abuse, Neglect, or Exploitation by others because of a mental or physical impairment. Vulnerable Adult includes an incapacitated person as defined in A.R.S. §14-1501.

POLICY

A. REPORTS TO DEPARTMENT OF CHILD SAFETY

1. Division staff who suspect Abuse of a Child or Neglect of a Child shall immediately report to the Department of Child Safety (DCS) in accordance with A.R.S. §13-3620.

    a. Reports must be made to DCS within 24 hours per instructions provided on the DCS website at https://dcs.az.gov/, including notification by phone: 1-888-SOS-CHILD (1- 888-767-2445), and documenting the Member's progress notes in Focus.

2. Division staff shall provide all pertinent information regarding the alleged Abuse or Neglect to the DCS worker, including:

    a. The names and addresses of the minor and their parents or person(s) having custody of such minor.

b. The minor's age and the nature and extent of their Abuse,Neglect, or Exploitation including any evidence of previous Abuse, Neglect, or Exploitation.

c. Any other information that might be helpful in establishing the cause of the Abuse, Neglect, or Exploitation.

3. Division staff shall cooperate with the DCS investigator during the DCS investigations.

4. Division staff shall submit a completed Incident Call Report (DDD-1746A-FORFF) to the appropriate District Incident Report mailbox when a report is made to DCS.

5. The Quality Management Unit shall triage all reported incidents to determine if the incident requires a quality of care investigation in accordance with Division Medical Policies 960 and 961.

B. REPORTS TO ADULT PROTECTIVE SERVICES

1. Division staff who suspect Abuse, Neglect, or Exploitation of an Adult shall immediately report to Adult Protective Services (APS).

2. Division staff shall report all pertinent information to APS, including:

a. The names and addresses of the Adult and any persons

having responsibility for or custody of the Adult, if known.

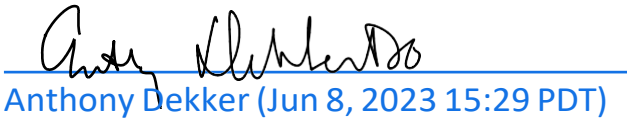
b. The Adult's age and the nature and extent of their incapacity or vulnerability.

c. The nature and extent of the Adult's Abuse, Neglect, or Exploitation.

d. Any other information that might be helpful in establishing the cause of Abuse, Neglect, or Exploitation.

3. Division staff shall submit a completed Incident Call Report to the appropriate District Incident Report mailbox when a report is made to APS.

4. The Division Quality Management Unit shall triage all reported incidents to determine if the incident requires a quality of care investigation in accordance with Division Medical Policies 960 and 961.

Signature of Chief Medical Officer: 
Anthony Dekker (Jun 8, 2023 15:29 PDT)
Anthony Dekker, D.O.

6002-I INCIDENT AND QUALITY OF CARE CONCERN CORRECTIVE ACTIONS AND CLOSURE

REVISION DATE: 8/2/23, 1/26/22, 11/29/17, 3/2/15

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §36-551; AMPM 960

PURPOSE

To establish the requirements for assigning Corrective Action Plans related to Incidents and Quality of Care Concerns, and closing cases.

DEFINITIONS

1. "Corrective Action Plan" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish Corrective Action Plan (CAP) goals and objectives, and staff responsible to conduct the CAP within established timelines.

2. "Incident" means an occurrence which has or could potentially affect the health and well-being of a Member enrolled with the Division of Developmental Disabilities or poses a risk to the community.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Member-Specific Corrective Action" means a corrective action that requires the Member's Planning Team to reconvene to discuss the Incident and review the need for any changes in the Planning Document or Risk Assessment to ensure the health and safety of the Member.

5. "Quality of Care Concern" means an allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services, which caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition, and may ultimately cause the risk of harm to a Member.

6. "Systemic Corrective Action" means a corrective action that requires the vendor to revise or clarify their own policy, procedure, implement specialized training of staff, or take other quality improvement actions to increase the ability of the vendor to improve the health and well-being of Members served.

7. "Systemic Concern" means a concern derived from tracking and trending that indicates an issue inherent in the overall system.

POLICY

A. CORRECTIVE ACTION PLANS

1. The Division's Quality Management Unit shall determine if an Incident is deemed a Quality of Care (QOC) Concern. A QOC may require corrective action(s) which could be Member-Specific or Systemic.

2. If a QOC investigation results in substantiated allegations, the Division's Quality Management Unit (QMU) Investigative Nurse shall:

   a. Request the service provider to submit a corrective action for each substantiated allegation;

   b. Track the requests for corrective action;

   c. Send follow-up requests to the service provider if the previous requests remain unmet; and

   d. Elevate the matter to QMU Leadership if the service provider is unresponsive to the requests for corrective action.

3. The Quality Management (QM) Nursing Supervisors shall make referrals to the Contract Action Unit and notify the Chief Quality Officer, QM Medical Director and Chief Medical Officer of the service

provider's non-compliance and involvement of the Contract Action Unit.

4. The Division shall conduct monitoring through Incident track and trend data or an onsite visit to validate sustainment of the vendor's submitted Corrective Action Plan (CAP).

5. The QM Nursing Supervisors shall elevate non-compliance with CAP remediation to the Chief Quality Officer, QM Medical Director and Chief Medical Officer, which may involve the Contract Action Unit.

B. INCIDENT CLOSURE

1. The QMU shall send an Incident that is not deemed a QOC Concern to the corresponding District personnel. The Division shall consider it complete when District personnel makes a notation in Focus and closes the file, which is to be kept on record for tracking and trending.

2. The Division shall consider an Incident that is deemed a QOC Concern by the Division's QMU complete when all the following are completed:

   a. The fact-finding and investigation are completed;

b. Recommendations for corrective action(s) are identified and communicated to the qualified vendor or provider of service;

c. QMU monitors the receipt of CAPs;

d. QMU approves the CAPs;

e. QMU monitors the implementation of CAPs and recommends closure when the remediation is complete;

f. Designated District personnel receive either a No Action Required letter or a Remediation CAP letter indicating that the investigation is complete, then verifies the information entered in Focus and closes the case; and

g. QMU Investigator submits the QOC to AHCCCS via AHCCCS QM Portal.

Signature of Chief Medical Officer: Anthony Dekker (Jul 31, 2023 16:49 PDT)
Anthony Dekker, D.O.

6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 6/14/23, 11/10/21, 11/29/17, 3/02/15
EFFECTIVE DATE: July 31, 1993

PURPOSE

To set forth the mortality review process and requirements used by the Division of Developmental Disabilities (Division) upon notification of deaths of Members served by the Division. The mortality review process is designed to identify issues and concerns that may have compromised the medical, behavioral, or overall care provided to a Member and trigger corrective action and strategies to mitigate future risk.

DEFINITIONS

1. "Fatal Five" means a group of preventable conditions that are often fatal for people with intellectual and developmental disabilities. They include aspiration, bowel obstruction, dehydration, gastroesophageal reflux, seizures.
2. "Member" means, for purposes of this policy, an individual enrolled with the Division of Developmental Disabilities at the time of death.
3. "Quality of Care Concern" means, for purposes of this policy, an allegation that any aspect of care or treatment, utilization of behavioral health services or utilization of physical health care

services, which caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition, and ultimately caused or contributed to the death of a Member.

4. "Support Coordinator" means an individual assigned as responsible for locating, accessing, and monitoring the provision of services to individuals in conjunction with a clinical team.

POLICY

A. NOTIFICATION

1. The Division may receive notification of a Member's death from various sources including:

    a. Vendors,
    b. Family members,
    c. Support coordinators,
    d. Health Care Services,
    e. Subcontracted health plans, and
    f. Claims data or eligibility files.

2. Upon notification of the death of a Member Division staff shall ensure that an incident report is completed and entered in the

Incident Management System.

3. A triage nurse shall send the incident reports involving a death of a Member to the Chief Medical Officer (CMO) or designee for review.

4. The CMO or designee shall notify the Quality Management Unit (QMU) for investigation if the CMO or designee determine a death should be reviewed as a Quality of Care (QOC) Concern.

5. A QMU investigative nurse shall prepare a monthly mortality tracker spreadsheet that contains information from all deaths in the Incident Management System database since the last reporting period, and includes information collected from other sources relevant to the death such as:

    a. The deceased Member's service plan,
    b. Information about the qualifying diagnosis(es) of the deceased Member,
    c. Identity of the provider of services at the time of death,
    d. Location of death,
    e. Any other recent incident reports involving the deceased Member, and

f. Support Coordinator progress notes.

B. MORTALITY REVIEW COMMITTEE

1. The Division's Mortality Review Committee shall meet monthly to review and discuss deaths of Members served by the Division, and includes:

   a. Reviewing the monthly mortality tracker spreadsheet;
   b. Determining unanimously that a death is explained, involved no QOC Concerns, and needs no further investigation;
   c. Referring cases to the QMU for further investigation if at least one committee member believes it should be a QOC Concern;
   d. Identifying process or systemic issues surrounding a death;
   e. Identifying and maintaining aggregate data on cases involving deaths from one of the Fatal Five and deaths related to Covid-19; and
   f. Making recommendations to develop or revise policies, procedures, and standard work.

2. The MRC shall not review any cases with an incomplete QOC investigation.

3. The QM Nurse Administrator shall forward the MRC meeting minutes to the Quality Management Subcommittee and the Quality Management/Performance Improvement Committee for reporting to Division Executive Leadership, including aggregate data on deaths from one of the Fatal Five and deaths related to COVID-19.

4. The Mortality Review Committee may directly refer cases to the Division's Peer Review Committee, if appropriate.

5. The QM Medical Director shall forward cases identified as peer review to the Nursing Program Administrator for tracking and presentation at the Peer Review Committee.

Signature of Chief Medical Officer: Anthony Dekker (Jun 8, 2023 15:16 PDT)
Anthony Dekker, D.O.

6002-N FRAUD AND FALSE CLAIMS

REVISION DATE: 07/28/2021, 10/1/2019, 11/29/2017, 6/10/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 13-1802, 13-2002, 13-2310, 13-2311, 36-2918; A.A.C. R6-6-801 et seq., R6-6-1001 et seq., R6-6-1101 et seq., R6-6-1501 et seq.; 42 CFR 455.2; Public Law No: 109-171 (Deficit Reduction Act of 2005); 31 U.S.C. § 3729-3733 (False Claims Act)

PURPOSE

This policy provides an overview of key provisions of the False Claims Act (FCA) and related legal requirements as required by the Deficit Reduction Act of 2005 (DRA) for the Division of Developmental Disabilities (Division). This policy defines fraud and describes the procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

POLICY OBJECTIVES

The objectives of this policy are to:

A. Prevent or detect fraud and abuse

B. Delineate reporting requirements

C. Define procedures

D. Explain Corporate Compliance

E. Describe training requirements

F. Specify policy requirements for providers

DEFINITIONS

Abuse - Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program as specified in 42 CFR 455.2.

Code of Federal Regulations (CFR) - is the codification of the general and permanent rules and regulations published in the Federal Register by the departments and agencies of the Federal Government.

Claim – Under the False Claims Act , the definition of “claim” includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

Deficit Reduction Act (DRA) –The Deficit Reduction Act of 2005, is a United States Act of Congress concerning the budget (Public Law No: 109-171 (02/08/2006)). It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

False Claims Act (FCA) - The FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs (31 U.S.C. § 3729-3733). It is the federal Government's primary litigation tool in combating fraud against the Government. The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law, as specified in 42 CFR 455.2. 42 CFR 455.2

An act of fraud has been committed when a member or provider:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government

Potential - Based on one's professional judgment, the appearance that an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practice, it may conduct a preliminary fact-finding to determine whether there is a sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention - Keeping something from happening.

Primary Contact - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS as specified in this policy.

Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

Remittance Advice - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

Waste - As defined by AHCCCS, the overutilization of services or other practices that result in unnecessary costs to the Medicaid program.

POLICY

PREVENTION AND DETECTION

The Division is committed to fostering a culture of compliance and an environment conducive to preventing and detecting fraud, waste, and abuse. The Division provides training to its employees about their role in reporting concerns and problems in relation to compliance and ethics. All Division employees are required to report any concerns relating to potential fraud, waste, and abuse, including false claims. This responsibility is intended to allow the Division to monitor and do improvement planning pertaining to false claims processing or other aspect of organizational compliance. Any employee who fails to report properly either through internal lines of communication or to AHCCCS Office of Inspector General (AHCCCS OIG), when that person knows of conduct constituting a violation of the FCA or any other related legal provision in the Division's Corporate Compliance Program, will be subject to discipline, up to and including termination.

As part of the Division's Compliance Program objectives, all employees, contractors, agents, subcontractors, in particular those involved in the provision or arrangement of provision of services, under government programs including members and providers, must report potential violations of this policy. Reports may be made anonymously; the person doing the reporting may request confidentiality and will be protected from any retaliatory action. The Division establishes internal controls on the member payment system including claim edits and prior authorization requirements. The Claims System is used to prevent and/or detect payments to providers when services were not performed, not authorized, or otherwise inappropriate. The original claims process is tested for the validity of its ability to detect fraud and misuse by reporting high utilization by members, underutilization by members, inappropriate service costs, and analyzing units by service title, month by month over the fiscal year. referral to AHCCCS OIG for suspicion of fraud, waste, or abuse. The Business Operations Unit conducts a post-payment review process, as outlined below:

A. Claims Edits

Claims are edited through a computerized system. During the initial processing of a claim, the claim is reviewed for items such as member eligibility, covered services, excessive or unusual services, duplication of services, prior authorization, invalid rate codes, and duplicate claims. Claims are reviewed if the provider has exhausted all authorized units.

The Division segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

Once claims are paid, the Division conducts a retrospective review of a sample of claims to ensure that the processing of the claim was specific to the processing instructions for the specific review. The Division conducts audits of claims payments to attain reasonable assurance that payments are being prepared correctly for the claims submitted by authorized providers for eligible AHCCCS members. The Division reviews detailed remittance advice. The Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services must receive prior authorization. Prior authorization criteria are determined using the guidelines set forth in DDD Provider Policy Manual and the AHCCCS Medical Policy Manual (AMPM).

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AMPM.

E. Contract Provisions

All providers must comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement."

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff.

Report suspected fraud, waste, or abuse via one of the following:

1. Call the toll-free DES/DDD Hotline at 877-822-5799.

2. Report the incident by completing the online referral form:

   https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

3. Mail to:

   DES/DDD
   Attention: Corporate Compliance Unit
   1789 W. Jefferson Street
   Phoenix, AZ 85007

4. Email: DDDFWA@azdes.gov

5. Contact AHCCCS through their website:

   https:/www.azahcccs.gov/Fraud/AboutOIG/

FALSE CLAIMS ACT

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $11,665 to $23,331 (adjusted time to time for inflation) for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistleblower" is protected under the FCA. The FCA and related law commits that no person will be subject to retaliatory action for reporting credible misconduct. Pursuant to the Division's commitment to compliance with the FCA and other applicable laws, no employee will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the Division solely because of actions taken to report potential fraud, waste and abuse, or other lawful acts by the employee in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

CORPORATE COMPLIANCE

The Corporate Compliance Officer implements, oversees, and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer is an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the Corporate Compliance Committee meeting held at least quarterly. The committee is a body comprised of the Chief Compliance Officer and Executive Leadership. Executive Leadership is limited to the following positions/designees:

- Assistant Director/Chief Executive Officer
- Office of Person-Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Chief Medical Officer

- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The Corporate Compliance Committee meeting includes information that has been forwarded for review through more frequent standing committees. Information that may be included at a Corporate Compliance Committee meeting includes but is not limited to:

- Incident Management System data (including suspected fraud)
- Resolution System data
- Program Monitoring reviews, claim disputes, appeals and state fair hearings
- Monthly meetings between the Attorney General's Office, Office of Administrative Review, Assistant Director and Executive Leadership to review any pending litigation
- Compliance Risk Management data analysis and remediation
- Development of strategies to promote compliance and detect any potential violations
- Development, implementation and monitoring of Corrective Action Plan (CAP)
- Training and Education
- Review of Compliance policies and procedures
- Approval of Standards of Conduct
- Identification of staffing needs and resources of the Compliance Unit
- Communications to all colleagues regarding compliance issues (e.g., HIPAA, Code of Conduct violations, Whistleblower Protections, False Claims)

The committee makes recommendations for improvement of the compliance program as identified through the analysis and review of reports. This committee is authorized to implement or require implementation of all necessary actions to ensure that the Division achieves the goals of an effective compliance program.

TRAINING

The Division provides training through the continuous core curriculum and computer-based training regarding fraud, waste, and abuse. The Corporate Compliance Unit provides additional in-service training to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

6003-C APPEAL PROCESS FOR MEMBERS WHO RECEIVE STATE FUNDED SERVICES

REVISION DATE: 8/28/2019, 2/26/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the Department of Economic Security (DES) Office of Appeals. The appeal request must be made in writing and received by Office of Administrative Review (OAR) no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3 3rd Floor, Suite 301p 2HE5
Phoenix, Arizona 85012

Once the hearing request is made, OAR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OAR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and the record supplied by OAR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified by the Hearing Officer of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than 15 calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-D NOTICE OF INTENDED ACTION (STATE ONLY)

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1802

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

A. Service denial, change, reduction, termination; or,

B. Eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action* or *Service System Discharge*, and include the following information:

A. The name and address of the responsible person;

B. The date that the notice is mailed;

C. The name of the member affected by this action;

D. The action that is being taken;

E. The effective date of the action;

F. The reason for the action;

G. What the member/responsible person can do if he/she does not agree with the action being taken; and,

H. The signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with interpretation.

6003-E ADMINISTRATIVE REVIEW PROCESS (STATE ONLY)

REVISION DATE: 8/28/2019, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1803

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Administrative Review (OAR). Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.

B. Responsible person's name, relationship, and telephone number.

C. Support Coordinator's name and telephone number.

D. Physician's name, if applicable.

E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3 3rd Floor, Suite 301p 2HE5
P hoenix, Arizona 85012

OAR will complete a review and investigation of the stated issues. OAR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OAR within 5 calendar days. OAR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if necessitated by a change in health status).

6003-F FAIR HEARINGS AND APPEALS

REVISION DATE: 02/22/2023, 03/02/2015

EFFECTIVE DATE: July 31,1993

REFERENCES: A.A.C R6-6-2201; A.A.C. R6-6-2202

PURPOSE

The purpose of this policy is to outline the process of appealing the outcome of an Administrative Review.

DEFINITIONS

1. "Administrative Decision" means the Division's written decision resulting from an Administrative Review.
2. "Appeal" means a request for a hearing pursuant to Article 22 under this Chapter to adjudicate the Division's Administrative Decision or proceeding pursuant to R6-6- 1808(B)(1).

POLICY

A. APPEALING AN ADMINISTRATIVE REVIEW DECISION

The Division shall accept a request for a hearing with the AHCCCS Administration to appeal the Administrative Decision when a member disagrees with a decision the Division rendered in an administrative review when:

1. The request is in writing, and
2. Filed no later than 15 calendar days of the personal delivery or postmark date of the Administrative Review decision.

B. FILING AN APPEAL

1. The Division shall consider appeals received when the document is received:
   a. Transmitted via the United States Postal Service, on the date it is mailed. The mailing date shall be:
      i. As shown by the postmark; or
      ii. As shown by the postage meter mark of the envelope in which it is received if there is no postmark; or
      iii. The date entered on the document as the date of its completion, if there is no postmark, or no postage meter mark, or if the mark is illegible.
   b. On the date it is received by the Department, if transmitted by any means other than the United States Postal Service.

c. The submission of any document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the Department that the delay in submission was due to Department error or misinformation, or to delay caused by the United States Postal Service.

2. The Division shall forward the request directly to the AHCCCS Grievance and Appeals Division.
3. Any document mailed by the Division shall be considered as having been served on the addressee on the date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated.
4. The Division shall advise the requestor of the right to counsel and, if requested, provide additional information on how to complete the hearing request.

6003-G MEMBER INQUIRY AND GRIEVANCE RESOLUTION

REVISION DATE: 1/10/2024, 4/29/2020, 8/14/2019, 4/10/2019, 6/10/2016, 3/2/2015

REVIEW DATE: 6/3/2023

EFFECTIVE DATE: July 31, 1993

REFERENCES: 45 CFR Part 164, 42 CFR Part 438, Subpart F, 42 CFR §§ 438.408(a) and (b), A.A.C. Chapter 34: R9-34-202, R9-34-209, R9-34-210 and R9-34-212, AHCCCS Contract, Section D, Program Requirements, 20 Grievance and Appeal System, AHCCCS Contract, Section F, Attachment F1.

PURPOSE

This policy outlines the Division's responsibilities when an Inquiry is received or a Grievance is filed with the Division's Customer Service Center (CSC).

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. § 1-301.
2. "Complainant" means the person(s) expressing the dissatisfaction or requesting to file a grievance.
3. "Functional Area" means a business unit or department within the Division.

4. "Grievance" means a verbal or written expression of dissatisfaction with any matter, other than an adverse benefit determination.

5. "Grievance Manager" means the individual who is assigned to work with the complainant through resolution.

6. "Inquiry" means a question received by the Customer Service Center.

7. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Quality of Care Concern" or "QOC Concern" means an

allegation that any aspect of care or treatment, utilization of behavioral health services, or utilization of physical health care services that:

a. Caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition; and

b. May ultimately cause the risk of harm to a member.

10. "Resolution System" means the application within Focus used to document Member and Provider Grievances.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. INTAKE TRIAGE

1. The Division's Customer Service Center (CSC) shall receive Inquiries and Grievances by:

   a. Phone - 1-844-770-9500 option 1, or

   b. Email - DDDCustomerServiceCenter@azdes.gov, or

   c. Mail - DES/DDD Customer Service Center

      1789 W. Jefferson St.

      Mail Drop 2HB3

      Phoenix, AZ 85007

   d. Referral from Division staff

2. The CSC shall evaluate each phone call, email, or letter received to determine if the correspondence is a Quality of Care Concern (QOC), an Inquiry, or a Grievance.

3. The CSC, when a QOC has been identified, shall:

   a. Notify the appropriate Functional Area immediately,

but no later than the close of the next business day, when an imminent health, safety, or clinically urgent risk exists.

b. Inform the individual who contacted the CSC that the concern will be elevated as a QOC and that the QOC triage process will be followed per Division Medical Policy 960.

4. The CSC shall respond to the Inquiry or inform the individual who contacted the CSC that they will be contacted within five Business Days when the Inquiry or Complaint is related to the Division, its contracted entities, or authorized services.

5. The CSC shall not disclose any confidential information in accordance with 45 CFR Part 164 Health Insurance Portability and Accountability Act (HIPAA) and in accordance with A.R.S. § 36-2917.

6. The CSC shall provide the individual who contacted the CSC with the contact information for the appropriate organization(s) when the Inquiry or Complaint is not

related to the Division, its contracted entities, or authorized services.

7. The CSC, when a Grievance is filed, shall provide the individual who contacted the CSC with their Grievance number and inform them they will be assigned a Grievance Manager who will work with them through resolution.

B. INQUIRY RESOLUTION

1. The CSC shall monitor Inquiries to ensure the individual who contacted the CSC is assisted timely.

2. The CSC shall maintain tracking logs that record the receipt, relevant information, and resolution of Inquiries.

3. The CSC shall request technical assistance when an Inquiry cannot be resolved timely.

4. The CSC shall resolve the Inquiry and provide the individual who contacted the CSC with a response.

C. GRIEVANCE RESOLUTION

1. The CSC shall provide the Complainant with a verbal

receipt of the Grievance at the time the Grievance is made and when requested by the Complainant, provide a written receipt of the Grievance.

2. The CSC shall document the receipt of the Grievance and the substance of the Grievance in the Division's Resolution System.

3. The CSC shall provide updates to the complainant on the progress of the Grievance.

4. The CSC shall ensure the person completing the Grievance investigation has no involvement in any previous level of review or decision-making regarding the Grievance.

5. The CSC shall ensure healthcare professionals have the appropriate clinical expertise to complete an investigation and make the decision when:

    a. A Grievance regarding a denial of an expedited resolution of appeal is received, or

    b. A Grievance involves clinical issues.

6. The CSC shall ensure all applicable documentation, including all aspects of care, is reviewed prior to making a decision.

7. The CSC shall engage additional Functional Areas when necessary to resolve the Grievance.

8. The CSC shall resolve the Grievance within 10 Business Days, but not to exceed 90 days, after the CSC receives the Grievance.

9. The CSC shall contact the Complainant to inform them of the resolution.

10. The CSC shall mail the Grievance disposition closure letter to the Complainant within 10 Business Days of resolution.

11. The CSC shall provide a Grievance disposition closure letter that includes a summary of the Grievance submitted and the resolution.

12. The CSC shall not provide the resolution in the Grievance disposition closure letter when the Grievance is closed due

to a QOC escalation.

13. The CSC shall ensure documentation of the Grievance, investigation steps, and actions taken for resolution are documented in the Division's Resolution System.

E. SUPPLEMENTAL INFORMATION

1. Refer to Division Operations Policy 446 for Grievances and Investigations concerning persons designated with a Serious Mental Illness.
2. For Provider Inquiries and Grievances, refer to Division Operations Policy 6003-H.

6003-H PROVIDER INQUIRY AND GRIEVANCE RESOLUTION

EFFECTIVE DATE: January 10, 2024
REFERENCES: Division Operations Policy 6003-G

PURPOSE

This policy outlines the Division's responsibilities when an Inquiry is received, or a Grievance is filed with the Division's Customer Service Center (CSC) by a Qualified Vendor or provider.

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. § 1-301.
2. "Complainant" means the person(s) expressing the dissatisfaction or requesting to file a grievance.
3. "Functional Area" means a business unit or department within the Division.
4. "Grievance" means a verbal or written expression of dissatisfaction with any matter, other than an Adverse Benefit Determination or provider Inquiries that are older than 30 days.
5. "Inquiry" means a question received by the Customer Service

Center.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. INTAKE TRIAGE

1. The Customer Service Center (CSC) shall receive Inquiries and Grievances by:
   a. Phone - 1-844-770-9500 option 1, or
   b. Email - DDDcustomerservice-providers@azdes.gov, or
   c. Mail - DES/DDD Customer Service Center
      1789 W. Jefferson St.
      Mail Drop 2HB3
      Phoenix, AZ 85007
   d. Referral from Division staff
2. The CSC shall evaluate each phone call, email, or letter received to determine if the correspondence is a Quality of Care Concern (QOC), an Inquiry, or a Grievance.
3. The CSC, when a QOC is identified, shall:
   a. Notify the appropriate Functional Area immediately, but no

later than the close of the next Business Day, when an imminent health, safety, or clinically urgent risk exists.

b. Inform the individual who contacted the CSC that the concern will be elevated as a QOC and that the QOC triage process will be followed as outlined in Division Medical Policy 960.

4. The CSC shall not disclose any confidential information in accordance with 45 CFR Part 164 Health Insurance Portability and Accountability Act (HIPAA) and in accordance with A.R.S. § 36-2917.

B. INQUIRY RESOLUTION

1. The CSC shall log and assign an Inquiry number when the Inquiry requires additional follow-up.

2. The CSC shall respond to the Inquiry or inform the individual who contacted the CSC that they will be contacted within three Business Days when the Inquiry is related to the Division, its contracted entities, or authorized services.

3. The CSC shall maintain a tracking log to record the receipt, relevant information, and resolution of Inquiries.

4. The CSC shall resolve the Inquiry and provide the individual who contacted the CSC with a response.

5. The CSC shall elevate any Inquiry not resolved within 30 days to a Grievance and document it in the Division's Resolution System.

C. GRIEVANCE RESOLUTION

1. The CSC shall provide the Complainant with a verbal or written receipt of the Grievance at the time the Grievance is made.
2. The CSC shall document the receipt of the Grievance and the substance of the Grievance in the Division's Resolution System.
3. The CSC shall provide updates to the Complainant on the progress of the Grievance.
4. The CSC shall engage additional Functional Areas when necessary to resolve the Grievance.
5. The CSC shall contact the Complainant to inform them of the resolution.
6. The CSC shall resolve a Provider Grievance within 30 days.
7. The CSC shall mail the Grievance disposition closure letter to the

Complainant within 10 Business Days of resolution.

8. The CSC shall provide a Grievance disposition closure letter that includes a summary of the Grievance submitted and the resolution.
9. The CSC shall not provide the resolution in the Grievance disposition closure letter when the Grievance is closed due to a QOC escalation.
10. The CSC shall ensure documentation of the Grievance, investigation steps, and actions taken for resolution are documented in the Division's Resolution System.

D. SYSTEMIC ACTION

The CSC, when Inquiry and Grievance trends are identified, shall take systemic action by elevating the trends to the CSC Managers and the Division's Leadership Team.

E. SUPPLEMENTAL INFORMATION

1. For Member Inquiries and Grievances, refer to Division Operations Policy 6003-G.
2. For Claim Disputes and Appeals, refer to Provider Chapter 11.

6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

REVISION DATE: 10/1/2021, 5/27/2020, 10/01/2019, 5/29/2019, 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R9-34-209, R9-34-216

Definitions

AHCCCS means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901.

Appeal means a request for review of an adverse benefit determination.

Administrative Services Subcontractors (AdSS) means an organization or entity that has a capitated contract with the Division to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, state statutes and rules, and Federal law and regulations.

Adverse Benefit Determination means any of the following:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

B. The reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a service;

D. The failure to provide services in a timely manner, as defined by the State;

E. The failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

F. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a member's request to exercise the right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

G. The denial of a member's request to dispute a financial liability, including cost sharing, co- payments, premiums, deductibles, coinsurance, and other member financial liabilities.

Arizona Revised Statutes (A.R.S.) means the statutory laws in the state of Arizona.

Arizona Administrative Code (A.A.C.) means the official publication of Arizona's codified rules.

Department means the Arizona Department of Economic Security.

Division means the Division of Developmental Disabilities within the Department.

Day means calendar day unless otherwise specified.

Enrollee means a person eligible for AHCCCS under A.R.S. Title 36, Chapter 29 and who is enrolled with an AHCCCS AdSS.

Filed means the date the AdSS or the Division, whichever is applicable, receives the request

as established by a date stamp on the request or other record of receipt.

Limited Authorization means a service authorization that falls short of the original request with respect to the duration, frequency, or type of service requested.

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

A. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489; or

B. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

1. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

2. Meets the solvency standards of 42 CFR 438.116.

Member means an individual enrolled with the Division.

Notice of Appeal Resolution means a written notice that includes the results of the resolution process per A.A.C. R9-34-216.

Notice of Adverse Benefit Determination means a notice that, per A.A.C. R9-34-205, explains:

A. The benefit determination the Division or AdSS has taken or intends to take;

B. The reasons for the benefit determination;

C. The enrollee's right to file an appeal with the Division or the AdSS;

D. The procedures for exercising the rights specified in Article 2 of A.A.C., Title 9, Chapter 34;

E. The circumstances under which an expedited resolution is available and how to request it; and

F. The circumstances under which an enrollee has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the enrollee is liable for the costs of services.

OAR means the Office of Administrative Review, which is the business unit within the Division of Developmental Disabilities responsible for processing member's appeals.

Prior authorization means a process used to determine in advance of provision whether a prescribed procedure, service, or medication will be covered.

Qualified Clinician means a behavioral health professional who is licensed or certified under A.R.S. Title 32 or a behavioral health technician who is supervised by a licensed or certified professional.

Recovering Costs means when the state fair hearing decision upholds the decision of the Division or the AdSS, the entities may initiate cost recovery for the service or services provided pending the outcome of the hearing decision. 42 CFR 431.230(b).

Representative means an individual authorized in writing by the responsible person to represent the member during the appeal process.

Responsible Person means the same as in A.R.S. § 36-551.

Rural means the same as in A.R.S. § 36-2171.

Seriously Mentally Ill (SMI) means persons who, as a result of a mental disorder as defined in section 36-501, exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, the mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation as in A.R.S. § 36-550.

Suspension of Service means a decision to temporarily stop providing a service that was previously authorized or approved.

Termination of Service means a decision to stop providing a covered service that was previously authorized or approved.

Working day means Monday, Tuesday, Wednesday, Thursday, or Friday from the hours of 8:00 a.m. to 5:00 p.m., unless:

A. A legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or

B. A legal holiday falls on Saturday or Sunday and the Division or AdSS is closed for business the prior Friday or following Monday.

Applicability

This policy applies to a decision made by the Division or its Administrative Services Subcontractors (AdSS) regarding:

A. Timely provision, approval, or authorization of a requested service or continuation of a covered service, benefit, or associated copayments including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

B. For members with SMI only, this also includes:

1. SMI Eligibility determination decisions

2. A PASRR determination related to a preadmission screening or an annual resident review which adversely affects member

3. Clinical Team findings regarding member's competency, capacity to make decisions, need for guardianship/other protective services or need for special assistance Planning Document or Inpatient Treatment and Discharge Plan (ITDP) service goals, objectives, or timelines and long-term views

4. Recommended services identified in assessment reports, Planning Documents, or ITDPs

5. Application of procedures and timeframes for developing a Planning Document or

ITDP

6. Sufficiency or Appropriateness of an Assessment

7. Access to or prompt provision of services identified in the Planning Documents or ITDPs

8. Denial of request to review outcome of, modification to, or failure to modify or termination of a Planning Document, ITDP or portion thereof

9. Decision to provide service planning including provision of an assessment or case management to a person who is refusing such services or a decision not to provide such services to the member

10. Decision regarding a person's fee assessment or the denial of a request to waive fees

11. Denial of payment of claims

12. Failure of the Division, AdSS, or AHCCCS to act within established Appeal timeframes

Non-Applicability

For members with SMI this procedure does not apply to:

A. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services

B. Title XIX Appeals of an adverse determination affecting services that are subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services, (See RHBA Contract Exhibit-14)

C. Adverse Determinations that are a result of changes in state or federal law requiring an automatic change or in order to avoid exceeding the legislatively appropriated state funding for program services and benefits

D. Allegations of rights violations made by members with SMI (See ACOM Policy 446)

E. Decisions involving a request for a service that requires a physician's order and the physician's refusal to order the service

Reasonable Entity for Appeals Process

The Division has delegated appeals to the AdSS for the following services:

A. Physical Health Care (i.e., prescription medications, DME, dental services, etc.)Behavioral Health Services

B. Seriously Mentally Ill (SMI) Services

C. Nursing Facility (NF) Services

D. Habilitative Physical Therapy for Members 21 Years of Age or Older

E. Emergency Alert System (EAS)

Filing an Appeal (Non-SMI)

When a Notice of Adverse Benefit Determination is given by the Division or the Administrative Services Subcontractors (AdSS) with whom the member/responsible person/representative does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person/representative.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Neither the Division nor AdSS allows punitive action against a provider for requesting expedited review of a member's appeal.

Filing an Appeal (SMI)

A member with SMI or the member's authorized representative may also appeal in writing or orally without prior receipt of a Notice of Adverse Benefit Determination when he/she is appealing any denial, decision, finding or recommendations outlined in the **Applicability** section of this policy pertaining to members with SMI only.

An authorized representative includes a legal guardian, guardian ad litem, designated representative or attorney, parent with legal custody, a court-appointed guardian ad litem or attorney of a member under 18 years, or a state or government agency that has executed an Intergovernmental/Interagency Service Agreement (IGA/ISA) with the Division for the provision of behavioral health services but which does not have legal custody or control of the member.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Appeal Filing Timeframes

Any member/responsible person/representative must file an appeal within **60 calendar days** after the date of the Notice of Adverse Benefit Determination either orally or in writing.

For members with SMI, an appeal may also be filed at any time even when there is no Notice of Adverse Benefit Determination when a member contests/disagrees with any denial, decision, finding or recommendation outlined in the **Applicability** section of this policy as referenced above.

For appeals from American Indian Health Plan members or appeals related to Long Term Services and Supports (LTSS) delivered by the Division to its members the appeal must be filed with the Division's Office of Administrative Review (OAR) at:

DDD Office of Administrative Review

4000 North Central Avenue
3rd Floor, Suite 301, Drop 2HE5
Phoenix, Arizona 85012
602-771-8163 or 1-844-770-9500

For appeals from members who are enrolled with an AdSS, member appeals must be filed to the

AdSS address specified in each Notice of Adverse Benefit Administration delivered to the member by the AdSS when it made its decision to deny, reduce, suspend or terminate a service. For appeals from **members with SMI who are enrolled with an AdSS**, appeal must be filed to the AdSS address or phone number listed in the Member's Handbook or communicated through the Health Plan Customer Services who will transmit this appeal request to the appropriate Appeals unit of the respective AdSS.

Each appeal receipt will be acknowledged in writing within **five calendar days**. At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal.

Late appeals will be accepted from an SMI member or his/her authorized representative only upon showing of good cause. If the Division or AdSS refuses to accept a late appeal or determines that a service may not be appealed, the Division or AdSS will inform the member/authorized representative, in writing that he/she may request an Administrative Review of the decision with AHCCCS within 10 business days. AHCCCS will issue a final decision on a timely request for Administrative Review within 15 calendar days of the request.

If the final day of any timeframe falls on a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a holiday.

The Division will assist the member/responsible person/representative with the completion of forms and other procedural steps, upon request. The member/responsible person/representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person/representative may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/representative is included as a party to the appeal process.

Appeal Notifications and Documents (SMI)

Notices and written documents will be available in each prevalent non-English language spoken within geographic service area. These will be made available in alternative formats such as Braille, large font, enhanced audio and other special communication devices and methods necessary to understand information. When needed, Oral interpretation services will be made available to members to explain written content contained in notices and written documents.

Member/authorized representative will not be made financially liable for all types of communication assistance provided.

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work or as specified in member/authorized representative's oral or written appeal.

Copies of notices will be maintained in the Division's official files using a unique docket number for each appeal filed. which will be referenced in all appeal correspondence generated. All records will be maintained in a secure and locked place in compliance with HIPAAA standards and requirements. The member/authorized representative will have the right to examine those documents and records maintained in member's docket file that will be used in informal conferences or Administrative Hearings upon request. The Division or AHCCCS may DENY access to Appeal case docket records when permitted by State and Federal law.

Continuation of SMI Services

If an appeal relates to the modification or termination of a behavioral health service, the service under Appeal will continue pending the resolution of the appeal through the Division's decision unless:

A. A Qualified Clinician (see definition) determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual or

B. The member or guardian, if applicable, agrees in writing to the modification or termination.

Appeal Resolution Process for Members with SMI

When the appealing member with SMI is enrolled with THP, the appeals process will be followed by the Division's OAR Appeals Unit. When the appealing member with SMI is enrolled with an AdSS, the Appeals Unit within each respective AdSS will follow the same appeal resolution process outlined below.

A. Division Informal Conference

1. Within seven days of receipt of an oral or written appeal, the Division or AdSS will hold an informal conference with the member/authorized representative. If member has been identified as needing special assistance and does not have an assigned Advocate, the Division or AdSS will contact AHCCCS Office of Human Rights to request for an advocate to be present during the informal conference or any part of the appeal process.

2. The Division or AdSS will schedule the informal conference at a convenient time and place and notify all participants in writing, at least two days prior to the scheduled conference listing date, time, location, and the option to participate by telephone or teleconference when preferred and the member's right to be represented by a designated representative of his/her choice.

3. The Informal Conference will be chaired by the designated representative of the Division or AdSS with authority to resolve the issues under appeal and who will seek to mediate and resolve the issues in dispute. The Division may designate a staff from its Behavioral Health Unit, Quality Management Unit, or Support Coordination to represent OAR during an informal conference.

4. During the informal conference the Division's designated representative will record a statement of the nature of the appeal, the issue presented, any resolution(s) agreed upon and the date(s) of implementation. Any unresolved issues will be identified for further appeal.

5. Upon a satisfactory resolution of member's appeal, the Division or AdSS will issue a dated written notice to all parties that contains the statement of the nature of the appeal, the issue addressed, the resolution(s) achieved, and the resolution implementation dates agreed upon.

6. If member's appeal is not resolved to member's satisfaction and the appeal issue does NOT relate to the member's eligibility for behavioral health services/SMI services, the member and other representative present during the Informal conference (member's designated representative/authorized representative, Advocate) will be informed that the appeal will be forwarded to AHCCCS for a

second informal conference. The procedure for requesting a waiver of the AHCCCS informal conference will be communicated to member/designated representative at this time.

7. If member's appeal is not resolved to member's satisfaction and the appeal issue relates to the member's eligibility for behavioral health services/SMI services, or the member has requested a waiver from the AHCCCS informal conference in writing, the Division or AdSS will:

   a. Provide a written notice to the member/authorized representative of the process to request an Administrative Hearing.

   b. Determine during the informal conference if the member/authorized representative or Advocate is requesting an Administrative Hearing. If so, the Division will file a request with AHCCCs within three business days of the informal conference.

   c. Send a copy of the Appeal, informal conference results, and written notice of the process to request an administrative hearing and notice of an Administrative hearing to the AHCCCS Office of Human rights for members in need of Special Assistance whether the member has an assigned Advocate who attended the informal conference or not.

8. For all appeals that are unresolved after an informal conference, the Division will forward the Appeal case record to AHCCCS within three days from the conclusion of the informal conference.

9. If the member fails to attend the scheduled informal conference and fails to notify the Division or AdSS, another informal conference will be rescheduled following written notification requirements followed previously.

10. If the member fails to attend the rescheduled informal conference and fails to notify the Division or AdSS prior to conference, the Division or AdSS will close the Appeal docket and send written notice of the closure to the member/authorized representative.

11. If the member requests the appeal to be re-opened due to failure to receive the informal conference notification and/or due to other good cause, the Division or AdSS may re-open the appeal and proceed with another informal conference.

B. Expedited Appeals Requests (SMI)

1. At the time an Appeal is initiated, the member may request an expedited Appeal in writing. The Division or AdSS will accept requests to expedite an Appeal for good cause, and for the following:

   a. A Denial of admission to or the termination of a continuation of inpatient services, or

   b. A Denial or termination of crisis or emergency services.

2. Within one day of receipt of a request for an expedited Appeal, the Division or AdSS will:

a. Inform the member in writing that the Appeal has been received and of the time, date, and location of the expedited informal conference; or

b. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal; and

c. Inform the member that he/she may, within three days of the Division or AdSS's decision, request an Administrative Review of the Division or AdSS's decision from AHCCCS.

3. Within two days of receipt of a written request for an expedited Appeal, the Division or AdSS will hold an informal conference to mediate and resolve the issues in dispute.

4. If the member requests an Administrative Review on a timely basis, AHCCCS will complete the review and issue a written decision within one day from the date of receipt. The decision of AHCCCS will be final.

C. AHCCCS Informal Conference

1. AHCCCS will hold another informal conference within 15 days of the notification from the Division that the Appeal was unresolved unless the member/authorized representative waives an informal conference with AHCCCS, or the appeal relates to eligibility for SMI services.

2. At least five days prior to the date of the AHCCCS-scheduled informal conference, AHCCCS will notify the participants in writing of the date, time, and location of the conference.

3. The informal conference will be chaired by a representative of AHCCCS who will seek to mediate and resolve the issues in dispute.The AHCCCS representative will record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further Appeal.

4. If the issues in dispute are resolved to the satisfaction of the member, AHCCCS will issue a dated written notice to all parties, which will include a statement of the nature of the Appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.

5. For a person in need of Special Assistance, AHCCCS will send a copy of the informal conference report to AHCCCS Office of Human Rights.

6. If the issues in dispute are not resolved to the satisfaction of the member, AHCCCS will:

a. Provide written notice to the member of the process to request an administrative hearing;

b. Determine at the informal conference whether the member is requesting AHCCCS to request an administrative hearing on behalf of the member and, if so, file the request within three days of the informal conference;

c. For a person in need of Special Assistance, send a copy of the notice to AHCCCS Office of Human Rights.

7. If the member requests an **expedited** AHCCCS Informal Conference, AHCCCS will hold an informal conference to mediate and resolve the issue in dispute, within two days of notification from the Division or AdSS, unless the member/authorized representative waives the informal conference, in which case the Appeal will be forwarded within one day to AHCCCS to schedule an administrative hearing.

8. If the AHCCCS informal conference is not waived, and AHCCCS fails to resolve the Appeal, the Appeal will be forwarded to AHCCCS to schedule an administrative hearing within one day of the informal conference.

9. If the member/authorized representative fails to attend the AHCCCS informal conference and fails to notify AHCCCS of this, AHCCCS may issue a written notice, within three working days of the scheduled conference, which contains a description of the decision on the issue under appeal and advises the member/authorized representative of his/her right to request an Administrative hearing.

10. In the event the member requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, AHCCCS may re-open the Appeal and proceed with the informal AHCCCS conference.

D. Requests for Administrative Hearing

1. In the event a request for administrative hearing is filed with the Division or AdSS, the Division or AdSS will ensure that the written request for hearing, Appeal case record, and all supporting documentation is received by AHCCCS within three days from such date. A written request for hearing filed by the Division or AdSS with AHCCCS will contain the following information:

   a. Name of the member and person receiving services (if different),

   b. Member's case docket number,

   c. The decision being Appealed,

   d. The date of the decision being Appealed, and

   e. The reason for the Appeal.

2. Administrative Hearings will be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

Standard Appeal Resolution Timeframe

The Division will respond to the standard appeal filed as a result of receipt of a Notice of Adverse Benefit Determination and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 30 calendar days after the date the Division receives the appeal. The Division will extend the 30-day timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division may request a 14-calendar day extension of the 30-day time frame if additional information is needed and the extension is in the best interest of the member. The OAR will provide the member/responsible person/representative written notice of the reason for the decision to extend the 30-day timeframe.

Appeal Notice Requirements

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work. In the event that it may be unsafe to contact the member/authorized representative at his/her home address, or the person indicated that he/she does not want to receive mail at home, the alternate communication methods specified by the member/authorized representative will be used.

Notices and written documents generated through the Appeals process will be available in alternative format such as Braille, large font, or enhanced audio and take into consideration the special communication needs of members.

Expedited Appeal

The member/responsible person/representative may request an expedited resolution of the appeal when the appeal is filed as a result of a Notice of Adverse Benefit Determination. The Division or AdSS will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person/representative, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the denial. It will send a written notice of the denial no later than two calendar days to the member/responsible person/representative. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 72 hours from the day the Division or AdSS receives the request for an expedited appeal. The Division or AdSS will extend the 72-hour timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division or AdSS may request a 14-calendar day extension of the 72-hour timeframe if additional information is needed and the extension is in the best interest of the member. The Division or AdSS will provide the member/responsible person/representative written notice of the reason for the decision to extend the 72-hour timeframe.

Appeal Decisions and Timeframes

For standard and expedited appeals filed as a result of a Notice of Adverse Benefit Determination, the Division will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 72 hours for an expedited appeal, the member may consider the appeal denied. The

Notice of Appeal Resolution is issued to the member/responsible person/representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD or Division) decision.

If the Notice of Appeal Resolution is reversed, the Division or AdSS will notify Support Coordination and the other entity (Division or AdSS), as appropriate. Upon notification, services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division may recover the cost of services from the member.

The Division or AdSS will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The AdSS will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division or AdSS will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or within 72 hours for an expedited appeal, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/representative and the Division through the Office of Administrative Review. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the AdSS decision.

If the Notice of Appeal Resolution is reversed, the AdSS or the Division of Developmental Disabilities, Office of Administrative Review by the other. Upon notification services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division or AdSS may recover the cost of services from the member.

6003-J ARIZONA LONG TERM CARE SERVICES STATE FAIR HEARING PROCESS

REVISION DATE: 8/28/2019, 04/24/2019, 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 41-1092.07

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings. The fair hearing request must be filed in writing and received by Office of Administrative Review (OAR) no later than 120 calendar days from the date of the Notice of Appeal Resolution. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301
Mail Drop 2HE5
Phoenix, Arizona 85012

Once the hearing request is filed, OAR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OAR staff will submit the file to AHCCCS within five (5) business days. This file will include the completed AHCCCS Submission of Request for Hearing form, a cover letter, copy of the entire file, copies of the Notice of Adverse Benefit Determination, request for fair hearing, investigative materials, and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is informal, and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence, and the record supplied by OAR and the appellant, the ALJ will prepare written findings of fact and conclusions of law and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OAR will arrange with the appropriate Division staff and/or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The rehearing will be decided by the AHCCCS Director or designee and a final written decision of the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-K CLAIM DISPUTES

REVISION DATES: 10/1/2021, 5/24/2021, 5/27/2020, 10/1/2019, 8/28/2019, 5/29/2019, 6/10/16, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-2903.01(B)(4) and 41-1092.01; A.A.C. R9-34-402 and R9-34- 405

Definitions

A. Administrative Services Subcontractors (AdSS) - means an organization or entity that has a capitated contract with the Division of Developmental Disabilities (Division) to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, Arizona statutes, Arizona rules, federal law, and federal regulations.

B. AHCCCS Administration - means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901(1).

C. Clean Claim - means the same as in A.R.S. § 20-3101(2).

D. Claim Dispute - A dispute, filed by a provider or DDD Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

E. Contractor - means the following:

1. A contractor or program contractor as defined in A.R.S. § 36- 2901(1);

2. The Comprehensive Health Plan (CHP) in the Department of Economic Security; and

3. The Children's Rehabilitation Services and Behavioral Health Services in the Arizona Department of Health Services.

F. Day - means calendar day unless otherwise specified.

G. Director - means the Director of the AHCCCS Administration or the AHCCCS Administration designee.

H. Director's Decision - means the final administrative decision under A.R.S. § 41-1092(5).

I. FFS Member - means a Fee For Service Member eligible for AHCCCS coverage under Arizona Revised Statutes Title 36, Chapter 29, who is enrolled with AHCCCS on an FFS basis, and who is not enrolled with an AHCCCS contractor.

J. Filed - means the date AHCCCS receives a request established by a date stamp on the request or other record of receipt.

K. State Fair Hearing - means an administrative hearing under Arizona Revised Statutes, Title 41, Chapter 6, Article 10.

Applicability

This policy is applicable to:

A. Fee for Service Providers who are filing claims and claim disputes to the Division for services rendered to the Division's THP members.

B. Providers who are affiliated with an AdSS which processes claims and claim disputes from its providers for services rendered to its enrolled members.

Claim Dispute Process

A Division representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division.

If the Division gives the service provider a notice that the service provider disagrees with, the service provider may file a claim dispute. The Division will accept a claim dispute only when the dispute involves a payment of a claim, a denial of a claim, an imposition of a sanction, or reinsurance.

The service provider must adhere to both of the following requirements when filing a claim dispute:

A. Submit the claim dispute to the Division in writing; and

B. Submit the claim dispute within the time period that will occur last out of the following, in accordance with A.R.S. § 36-2903.01(B)(4):

   1. Within the 12 consecutive months immediately following the date(s) of service;

   2. Within the 12 consecutive months immediately following the date that the member's eligibility is posted; or

   3. Within the 60 calendar days immediately following the date of denial for a timely claim submission.

The Division will date all claim disputes upon the Division's receipt. The Division will send the service provider a written notice acknowledging receipt of the claim dispute within the five business days immediately following the Division's date of receipt. If the service provider wishes to submit any additional information to the Division for consideration, the service provider must submit the additional information within the 10 calendar days immediately following the Division's date of receipt. The Division will advise the service provider about the 10-day deadline for the service provider to submit any additional information.

Division Business Operation staff may contact the service provider to obtain additional information. The Division will consider and review, relevant Arizona Revised Statutes, Arizona Administrative Code, AHCCCS policies, and Division policies. The Division staff will be consulted, as necessary.

The Division will investigate every claim dispute using applicable authorities and facts obtained from all parties. Both the Division and the service provider must mutually agree to any deadline

extension(s). If both parties mutually agree to extend the decision deadline either to allow additional time for the Division to make a decision or the service provider to submit supporting documentation, the Division will issue a letter to the service provider.

When the Division completes the fact-finding, the Division will render a written Notice of Decision to the service provider. The Division will send the Notice of Decision within the 30 calendar days immediately following the Division's date of receipt unless the parties mutually agree to a deadline extension.

The Notice of Decision must both comply with relevant regulatory and contractual requirements, as well as include all of the following:

A. The date of the decision,

B. The factual and legal basis for the decision,

C. The service provider's right to request a fair hearing, and

D. The instructions for requesting a fair hearing.

State Fair Hearings for Claim Disputes

If a service provider disagrees with the Division's Notice of Decision on the service provider's claim dispute, then the service provider may file a request for a fair hearing with the Department of Economic Security (DES) Appellate Services Administration/Arizona Long Term Care System (ALTCS). The service provider must make the fair hearing request in writing to the Office of Administrative Review (OAR) within the 30 calendar days immediately following the Division's dated receipt of the Notice of Decision.

The service provider must send the fair hearing request to:

DES/DDD Office of Administrative Review (OAR)
4000 N. Central Ave, 3rd Floor Suite 301
Phoenix, Arizona 85012

Once the fair hearing request is made, OAR staff will prepare a duplicate file and submit the duplicate file with the hearing request to both the DES Appellate Services Administration/ALTCS and the Attorney General's Office. The OAR staff will prepare the duplicate file to include all of the following:

A. Copies of the claim dispute,

B. Investigative materials, and

C. The Notice of Decision.

OAR staff will submit the documents to the DES Appellate Services Administration/ALTCS within the five business days immediately following the Division's dated receipt of the request for hearing.

A DES Appellate Services Administration/ALTCS representative will schedule the fair hearing. The service provider will receive written notification of the fair hearing's scheduled date and time. The DES Appellate Services Administration/ALTCS representative will notify both the

Attorney General's Office and the OAR about the scheduled hearing.

At the fair hearing, the service provider, a DES/Division of Developmental Disabilities (DDD) representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/ALTCS Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, written conclusions of law, and render a decision. The Hearing Officer will render the decision based on the following:

A. Information the Hearing Officer gathers through testimony,

B. Any presentation of evidence, and

C. Any other records supplied by OAR.

A DES Appellate Services Administration/ALTCS representative will forward a copy of the decision to all of the following:

A. The AHCCCS Office of Administrative Legal Services,

B. The service provider,

C. DES/DDD, and

D. The Attorney General's Office.

If the service provider wants to petition for rehearing or review, then the service provider must submit the request to the AHCCCS Office of Administrative Legal Services within the 30 calendar days immediately following the date of the DES Appellate Services Administration/ALTCS Administrative Law Judge's decision. The petition must completely explain the grounds for a rehearing or review.

Petitions for rehearing or review must be sent to:

AHCCCS Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division's decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If the Division and the Attorney General's Office decide a review will not be petitioned, the OAR will arrange with the appropriate Division staff to both authorize payment and pay for the services as reasonably expeditious as possible.

If the Division or the service provider is still dissatisfied with the AHCCCS decision, the Division or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reversed Claim Disputes

The Division shall reprocess and pay both overturned and reversed claim disputes within the 15 business days immediately following the date of the decision. The Division will make payments

in a manner consistent with the decision.

IMPORTANT TO NOTE: The Division will adhere to the same claim dispute process described herein for FFS claims on behalf of THP members.

THE DIVISION HAS DELEGATED ACUTE CARE CLAIM DISPUTES TO THE ADSS FOR ADJUDICATION FOR ALL THE FOLLOWING SERVICES:

- Physical Health Care (i.e., hospitalizations, prescription medications, DME, dental services, etc.)
- Behavioral Health Services
- Seriously Mentally Ill (SMI) Services
- Nursing Facility (NF) Services
- Habilitative Physical Therapy for Members 21 Years of Age or Older
- Emergency Alert System (EAS)

Claim Dispute Process

The AdSS representative will provide written notice advising the service provider of both a denial of claim payment and the reason for denial. The AdSS representative may include the notice either in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the AdSS.

If the service provider disagrees with a notice given by the AdSS, the service provider may file a claim dispute. The AdSS will accept a claim dispute only if the dispute involves one of the following:

A. A payment of a claim,

B. A denial of a claim,

C. An imposition of a sanction, or

D. Reinsurance.

The service provider must file the claim dispute in writing with the AdSS. In accordance with

A.R.S. § 36-2903.01(B)(4), the service provider must submit the claim dispute within the time period that will occur last out of the following:

A. Within the 12 consecutive months immediately following the date(s) of service,

B. Within the 12 consecutive months immediately following the date that the member's eligibility is posted, or

C. Within the 60 calendar days immediately following the denial date of a timely claim submission.

The AdSS will date all claim disputes upon AdSS's receipt. The AdSS will send the service

provider a written notice acknowledging receipt of the claim dispute within the five business days following the date the claim dispute is received. The AdSS will advise the service provider that any additional information the service provider wishes to submit to the AdSS for consideration must be done so in 10 calendar days.

The AdSS staff may contact the service provider to obtain additional information. Relevant Arizona Revised Statutes, Arizona Administrative Codes, and AHCCCS and Division policies will be reviewed, and the AdSS staff will be consulted as necessary.

AdSS will investigate all claim disputes using applicable authorities and facts obtained from all parties. Both parties must mutually agree on any deadline extensions. If there is a mutual agreement to extend the decision due date either to allow the AdSS to make a decision or allow the service provider additional time to submit supporting documentation, the AdSS will issue a letter to the service provider. Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within 30 calendar days of receipt of the services provider's claim dispute unless the provider and the AdSS agree to a longer period.

The Notice of Decision must comply with regulatory and contractual requirements. The Notice of Decision must include all of the following:

A. The date of the decision,

B. The factual basis for the decision,

C. The legal basis for the decision,

D. The service provider's right to request a fair hearing, and

E. The instructions for requesting a fair hearing.

State Fair Hearings for Claim Disputes

If a service provider disagrees with the AdSS's Notice of Decision on a claim dispute, the service provider may file a request for a fair hearing with the Office of Administrative Hearings (OAH). The service provider must make the request for fair hearing in writing to the AdSS within the 30 calendar days immediately following AdSS's receipt of the Notice of Decision.

In accordance with DDD Operations Manual Policy 445, the AdSS will forward the service provider's fair hearing request file to the Division's Office of Administrative Review (OAR) to be submitted to the AHCCCS Office of Administrative Legal Services (OALS). The AdSS staff will prepare a duplicate file along with the hearing request, copies of the claim dispute, investigative materials, and the Notice of Decision for submission to the DDD Office of Administrative Review (OAR). The AdSS will submit the duplicate file to the DDD Office of Administrative Review (OAR) within the three business days immediately following AdSS's receipt of the request for fair hearing. OAR staff will submit the documents to the AHCCCS Office of Administrative Legal Services (OALS) within the two business days immediately following OAR's receipt of the file from the AdSS.

The fair hearing will be scheduled by the AHCCCS Office of Administrative Legal Services (OALS). The service provider will receive written notification of the date and time. The AHCCCS Office of Administrative Legal Services (OALS) will notify both the AdSS and the Division of the scheduled hearing.

At the hearing, the service provider, an AdSS representative, and the AdSS General Counsel, if appropriate, will meet with an Office of Administrative Hearings (OAH) Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, conclusions of law, and render a decision. The Hearing Officer will render a decision based on the following:

A. Information gathered through testimony,

B. Any presentations of evidence, and

C. Any other records from the AdSS or service provider.

An Office of Administrative Hearings (OAH) representative will forward a copy of the decision to the Arizona Health Care Cost Containment Service (AHCCCS) Director.

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the AdSS decision, the AdSS will determine if a request for review will be petitioned to the AHCCCS Director. If the AdSS decides that a review will not be petitioned, the AdSS will arrange with the appropriate AdSS staff to both authorize and pay for the services as expeditiously as reasonably possible.

Parties may file a petition for rehearing or review with the AHCCCS Office of Administrative Legal Services (OALS) by the AdSS or service provider. The petition must be submitted within the 30 calendar days immediately following the date of the AHCCCS Director's decision. The petition must completely explain the grounds for rehearing or review.

Petitions for rehearing or review must be sent to:

AHCCCS Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

If the AdSS or the service provider is still dissatisfied with the decision, the AdSS or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reversed Claim Disputes

The AdSS must reprocess and pay overturned or reversed claim disputes within the 15 business days immediately following the date of the decision. The AdSS will make payments in a manner consistent with the decision.

6003-L ATTORNEYS AT PLANNING MEETINGS

REVISION DATE: 5/20/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The member/responsible person may invite anyone to participate at planning meetings, including his/her attorney. It is recommended that the member/responsible person notify the Support Coordinator, at least two business days before the meeting is scheduled to occur, that legal counsel will participate with the responsible person at the planning meeting.

If prior notice is not given, the planning meeting may be postponed. If the Division's legal counsel is not present at the meeting and Division staff determines that legal counsel is needed, Division staff may temporarily stop the meeting in an effort to obtain legal counsel. In addition to Division staff, the Division may have an Assistant Attorney General at a meeting. Any meeting may be audio recorded.

6003-N ORAL AND WRITTEN REGULATORY INQUIRIES

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 U.S. Code § 1396u–6, 42 U.S.C. § 1396w–2, 42 U.S.C. § 1396w–5

PURPOSE

To comply with applicable statutes, regulations, contractual program requirements and maintain the integrity of the Compliance Program, the Division shall document and track oral and written inquiries and responses.

DEFINITIONS

Member Information Materials – Any materials given to DDD membership. This includes, but is not limited to member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone

Vital Materials – Written materials that are critical to obtaining services which include, at a minimum, the following:

1. Member Handbooks
2. Provider Directories
3. Consent Forms
4. Appeal and Grievance Notices
5. Denial and Termination Notices Policy A. Member Information Materials

POLICY

The Corporate Compliance Officer or designee shall ensure the log for regulatory inquiries is completed daily. The log shall be available for review during any internal and external audits. Any requests for information, guidance, and advice from any government agency, fiscal intermediaries, subcontractors, vendors, providers, agents, and members shall be documented on the log.

The logging of oral inquiries is extremely important if Division relies on the response as guidance in future decisions, actions, or claim reimbursement requests or appeals. The Corporate Compliance Team process regulatory inquiries as follows:

1. DDD Long Term Care Services – Contract Compliance Unit
2. Acute Services Health Plans – Health Plan Compliance Unit

In addition, the log shall be relevant in a subsequent investigation to the issue of whether Division's reliance was "reasonable" and whether it exercised due diligence in developing procedures and practices to implement the advice.

This policy pertains to oral and written communication disseminated to the Division's enrolled members and to the content of the Division's website.

A. The Division must comply with the requirements in this Policy for all member information materials as outlined in the Division's Operations Manual and AHCCCS Contractor Operations Manual (ACOM):

1. Chapter 400 Operations

2. Chapter 404 Contractor Website and Member Information

3. ACOM Policy 405 for requirements regarding Cultural Competency, Language Access Plan and Family/Patient Centered Care

4. ACOM Policy 406 for requirements regarding the Member Handbook and Provider Directory

5. ACOM Policy 425 for requirements regarding Social Networking activities

6. ACOM Policy 433 for requirements regarding Member ID Cards

7. ACOM Policy 414 for sample Notice of Adverse Benefit Determination and Notice of Extension

8. The Division Contract, Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters.

9. The Division must attest it is in compliance with member information requirements by signing and submitting ACOM 404, Attachment C, as specified in the Contract.

B. The Division must provide all member information materials to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.

C. The Division must inform members that member information is available in paper form, without charge and upon request, and must provide it upon request within five business days.

D. The Division must use State developed member notices as indicated in Contract and Policy [42 CFR 438.10(c)(4)(ii)].

6003-O RESPONDING TO GOVERNMENT AUDITS

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 455, Subpart A, A.R.S. §§36-2918 and 2957

PURPOSE

To establish a procedure for responding to government audits, interviews, and investigations beyond routine claims reviews.

DEFINITIONS

Federal Bureau of Investigation (FBI) – The investigative arm of the federal government

Centers for Medicare and Medicaid Services (CMS) – The federal agency overseeing the administration of the Medicare and Medicaid programs.

Medicaid Fraud Control Unit (MFCU) - The investigative arm of the state Medicaid agency.

Office of Inspector General (OIG) - The legal investigative arm of federal government programs.

State Attorney General's Office (AGO) - The legal prosecutorial arm of State government.

State Government Agency/AHCCCS - Any state agency responsible for clinical licensure or oversight of healthcare providers.

POLICY

The AHCCCS Office of Inspector General (AHCCCS-OIG) has the authority to conduct preliminary and full investigations relating to fraud, waste, and abuse involving the programs it administers. Pursuant to 42 CFR 455, Subpart A, an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG has the authority to make independent referrals to other law enforcement entities.

Pursuant to A.R.S. §36-2918, AHCCCS-OIG has the authority to issue subpoenas and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the Office.

Pursuant to A.R.S. §§36-2918 and 2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National

Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, AHCCCS-OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

RESPONSIBILITIES

The Corporate Compliance Officer or designee is responsible for leading the response to as well as coordinating and tracking all details of government audits, interviews, and investigations.

GUIDELINES

Federal and state governments have made the investigation and prosecution of healthcare fraud one of their highest priorities. They have also proposed many new initiatives for identifying fraudulent and abusive practices. A number of these initiatives include conducting audits of vendors. The Division's policy requires the implementation of internal controls to provide reasonable cooperation with these government authorities while at the same time protecting the rights of the Division and its employees.

A. Non-Routine Communication from Government Representatives

1. To fully understand a request from a government representative and provide a complete and accurate response to non-routine requests from a government representative, all such communications must be forwarded to the Corporate Compliance Officer.

2. Any employee receiving a nonroutine request or communication from a government representative should obtain the following information for the Corporate Compliance Officer or designee:

    a. The person's name, title, and department (if possible, obtain a business card), badge or identification number; for telephone requests, the office telephone number of the government representative; and

    b. As many details as possible about the information or documents being requested.

    c. If a list of requested items/documents is provided, prepare a copy of each document.

3. Inquiries into the location of files must be answered truthfully. All requests from a government representative to obtain any documents from the Division must be immediately forwarded to the Office of Administrative Review.

4. If an employee is contacted by an organization that is not on the list of agencies in the Definitions and Acronyms section of this policy and is unsure whether the organization is a federal or state government agency, they should contact their direct supervisor/manager, the Corporate Compliance Officer or designee directly.

5. If a request for documents or a subpoena is received from a government representative, it should be immediately forwarded to a supervisor/manager. The supervisor/manager should immediately send a copy to the Corporate Compliance Officer.

    a. Employees should not respond directly to the request until receiving direction from their supervisor/manager.

B. Interviews with Government Representatives

1. It is appropriate to respond to unannounced visits from a government representative with a reasonable request to schedule an appointment to speak with the representative at a later date. Any employee receiving an unannounced visit from a government representative should immediately contact their supervisor/manager and/or the Corporate Compliance Officer or designee, or AD for direction.

2. Division employees must contact their supervisor/manager and/or the Compliance Officer or designee as soon as possible after the contact by the government representative.

3. Employees are encouraged to take notes during any encounters with government representatives.

4. Division employees may have someone present during any interview with a government representative. The Division may arrange to have an appropriate individual (possibly an attorney) present at no cost to the employee or employees may consult with an attorney of their own choosing at their expense.

5. When a Division employee speaks with a government representative, they should answer the questions completely, accurately, and concisely to prevent any misunderstanding of the facts.

C. Searches by Government Representatives

1. Division employees should be courteous and helpful to government representatives but should not grant access for a search without guidance from a supervisor/manager, the Corporate Compliance Officer or designee, or AD.

2. A government search may not be conducted without a legally valid search warrant. Division employees should request time to contact the Corporate Compliance Officer and legal counsel to determine the validity of a search warrant.

3. Division employees must not:

    a. Alter or destroy documents sought in an investigation

    b. Falsely deny knowledge of information

c. Seek to influence another person to exercise the privilege against self-incrimination

d. Intimidate a witness with the intent of influencing testimony; or

e. Retaliate against a witness for testifying in an official proceeding.

4. Any Division employee that observes this prohibited behavior should immediately report this to the Corporate Compliance Officer.

5. Division employees should, when possible, make copies of all documents requested by a government representative. A government representative should not remove documents from the Division's premises without the Division first maintaining a copy of the documents. The Office of Administrative Review will provide instructions on the maintenance of these documents.

6. If a Division employee cannot make copies of all requested documents, they should request and obtain from the government representative a detailed log of all documents or items copied or removed.

7. Division employees are not authorized to sign, on behalf of the Division, any document that a government representative requests be signed. If a government representative requests that a Division employee sign an affidavit, that employee may request to have legal counsel review it before signing it.

D. Communications Regarding an Investigation

1. Inquiries for information from the media should be referred to the Department of Economic Security Public Information Officer (DES-PIO) at PIO@azdes.gov. Whenever possible, the employee should obtain the identity and telephone number of the inquiring party and provide that information to the Public Information Officer.

E. Administrative Issues

1. The Corporate Compliance Officer or designee will follow the Compliance Program policy and procedure for creation, maintenance, and retention of the documents related to a government audit, interview, or search under the guidance of legal counsel.

6003-R COMPLIANCE CONCERNS AND REPORTING REQUIREMENTS

REVISION DATE: 9/15/2021
EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 455.17, CMS FWA Reporting, MIP Manual, AAC R6-6-1517

PURPOSE

To ensure Division employees understand it is everyone's responsibility to assist in preventing, identifying, and reporting any suspicion of fraud, waste, and abuse of the Division's programs.

POLICY

To encourage and establish communications for Division employees that shall remain "confidential and non-retaliatory" regarding reporting misconduct. Reporting of fraud, waste, and abuse shall be completed without retribution and retaliation of the individual reporting or filing a complaint. Employees shall report suspicion about legal and/or ethical violations.

A. Opening lines of communication between the Corporate Compliance Officer/Compliance Unit and Division employees is critical to the successful implementation of a Compliance Program and the reduction of potential Fraud, Waste, Abuse, and misconduct.

B. In addition to serving as a contact point for reporting non-compliance, the Corporate Compliance Officer/Compliance Unit shall be a resource to whom staff can receive clarification regarding policies related to corporate compliance.

C. Questions and responses shall be documented and dated and, if appropriate, addressed with the Corporate Compliance Committee so that standards and policies can be improved to reflect any necessary changes or clarification of existing Policies and Procedures.

D. Division employees shall report legitimate concerns about legal, ethical, or quality of care issues. Any activity that may compromise a member's health, safety, or welfare and/or the Division's reputation related to ethical health care and business practices shall be reported to the Corporate Compliance Officer/Compliance Unit immediately.

E. The Corporate Compliance Committee members or the established Corporate Compliance Program Integrity hotline is another means by which reporting may occur.

F. Each employee shall be encouraged, but not required, to follow the chain of command when reporting any allegation(s) involving suspected fraud, waste, or abuse in Medicare and Medicaid programs:

G. The Division's Corporate Compliance Officer (Compliance Officer) and Corporate Compliance Unit shall be the first point of contact for employees to report any allegations of fraud, abuse, or waste.

H. Suspected fraud, waste and abuse may be reported via one of the following mechanisms:

Fraud Contact Information

DDD Corporate Compliance Unit

Phone: 1-877-822-5799

Online: https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

Email: dddfwa@azdes.gov

Or Write to:
DES/DDD
Attn: Corporate Compliance Unit
1789 W Jefferson St.
Mail Drop 2HA1
Phoenix, AZ 85007

AHCCCS OIG Fraud Prevention Unit

Phone: (602) 417-4193

Online: https://azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

Provider Fraud:

Maricopa County: (602) 417-4045
Outside Maricopa County: (888) 487-6686

Member Fraud:

Maricopa County: (602) 417-4193
Outside Maricopa County: (888) 487-6686
General Questions:
Email: AHCCCSFraud@azahcccs.gov

I. Each employee has the right to remain anonymous when reporting any suspected allegations of fraud, waste, or abuse to Medicare, Medicaid, or other programs. The reporting process may be written or verbal.

J. The Compliance Officer or designee that receives reports of fraud, abuse, or waste may retain the confidentiality of staff member(s) who report information as deemed appropriate.

K. When reporting a compliance concern other than suspected fraud, waste and abuse, staff shall include information the Compliance Officer or designee will need to follow up. This includes but is not limited to:

1. The location where the concern occurred or is occurring
2. The date or dates of any incident
3. The names and job roles of individuals involved in the concern
4. A description of the concern
5. The name of the staff submitting the report
    a. If the person is comfortable letting the Compliance Officer/Office know.
    b. If the staff member is not comfortable leaving their name, staff may make an anonymous report by calling the FWA & Misconduct hotline or reporting directly to AHCCCS.

L. Anyone making such a report is assured that it will be treated as confidential and will be shared with others only on a need-to-know basis.

M. To protect those involved in a compliance investigation, the findings of the compliance investigation remain confidential. Therefore, details of the investigation shall be shared only on a need-to-know basis.

N. The Compliance Officer or designee ensures that all reports will be thoroughly and fairly investigated.

O. No adverse actions will be taken against someone for making a report in good faith or for cooperating with a compliance investigation in good faith.

6003-S COMPLIANCE PROGRAM TRAINING AND EDUCATION

EFFECTIVE DATE: September 8, 2021
REFERENCES: Division Operations Manual Chapter 6000 C. 1. A. v., 6000 C. 2, 6004-F, Compliance Program Components A, ACOM Chapter 100 Part B. 9, 10XXXXX

PURPOSE

To establish procedures for the mandatory compliance training and routine dissemination of information related to compliance activities.

POLICY

The Division will provide education and training related to compliance requirements and standards, to offer guidance, promote an organizational culture of ethics and compliance, and provide an environment in which stakeholders can act in good faith without fear of retaliation.

RESPONSIBILITIES

The Corporate Compliance Officer will ensure Division procedures for providing education and training are followed. In their absence, the Assistant Director will appoint an appropriate staff member.

GUIDELINES

Education and training are key factors in ensuring the effectiveness of the Division's Compliance Program. The Division must educate its employees on applicable federal, state, local, contractual, and organizational regulations by which the Division is governed. This includes the organization's policies the Division is committed to uphold. It is vital that all employees are informed of their individual responsibility to understand and comply with these regulations and policies. As a result, the Division's Compliance Program has established the following education and training policy.

A. Compliance Program Training Materials

1. The Corporate Compliance Officer or designee will create or oversee the creation of all training presentations and materials related to the Compliance Program, including the date on which the document was created and updated, if applicable.

2. The Corporate Compliance Officer or designee will review all Compliance Program training presentations and materials on an annual basis for content, and update as necessary to comply with, and include any regulatory changes.

3. The Compliance Officer or designee in coordination with the Office of Professional Development (OPD) will maintain a record of all compliance training programs, including training presentations, attendance records, and other related materials such as handouts and test results.

B. Compliance Program Orientation Training

1. The Corporate Compliance Officer or designee is responsible for ensuring that all new Division employees and associates receive the most current version of Compliance Program Orientation Training within 90 days of hire.

2. The Corporate Compliance Officer or designee will create and maintain records of training materials and attendance reports in the Corporate Compliance Unit permanent files.

C. Compliance Program Annual Refresher Training

1. The Corporate Compliance Officer or designee in coordination with OPD, is responsible for ensuring that all Division employees receive the most current version of Compliance Program Refresher Training every calendar year.

2. The Corporate Compliance Officer or designee will receive Refresher Training materials and attendance reports from OPD and monitor compliance.

3. The Corporate Compliance Officer or designee will work with OPD to coordinate Refresher Training.

D. Dissemination of Compliance Program Information

1. The Corporate Compliance Officer or designee in coordination with the Communications and Customer Care Units, is responsible for ensuring that Division employees are informed of compliance regulatory changes, events, and news, as it relates to Division services.

2. The Corporate Compliance Officer or designee may use a variety of tools or formats for these updates/newsletters, including, but not limited to e-mail bulletins, conference calls, and notices posted in employee break areas.

6003-U CORPORATE COMPLIANCE PROGRAM DOCUMENTATION

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 438.608, ACOM Policy 103, AHCCCS contract with DDD Section D paragraph 65 and 66

POLICY

To outline the process for establishing documentation creation, maintenance, and retention procedures for compliance activities such as:

A. Development and implementation of written policies and procedures

B. Reporting to the Compliance Committee

C. Training and Education

D. Developing effective lines of communication

E. Conducting internal and external monitoring and auditing

F. Enforcing standards through well publicized disciplinary guidelines

G. Responding promptly to detected noncompliance and undertaking corrective action

DOCUMENTATION

The Division's Corporate Compliance staff shall take steps to document its compliance processes. The Corporate Compliance Officer (Compliance Officer) will ensure procedures for document control are followed. In their absence, the Assistant Director (AD) or Corporate Compliance Committee will appoint an appropriate staff member.

Documentation is a key factor in the determination of a Compliance Program's effectiveness. An organization must be able to demonstrate the actions that have been taken throughout the development and implementation process to evaluate the reasonableness of decisions made in establishing and maintaining the program. Therefore, the Division's Compliance Program has established the following documentation guidelines to assist in creating an electronic record of the Division's compliance activities.

A. Maintenance of Compliance Program Documents

1. The Compliance Officer or designee will create and maintain and oversee the maintenance of all documentation of the Compliance Program, including the date on which the document was created and updated, if applicable.

2. The Compliance Officer or designee will maintain a log of all compliance-related documents of which he/she is aware or that are in his or her possession.

3. The Compliance Officer or designee may generate or receive documents that are of a confidential nature. These may include business documents, investigation materials, or member records that must be protected from

general disclosure or distribution. The Compliance Officer, in consultation with legal counsel when appropriate, will determine which documents should be maintained as "CONFIDENTIAL" documents. Each page of these documents will be labeled "CONFIDENTIAL/DO NOT DUPLICATE."

4. Records generated or obtained by the Compliance Officer or designee in the course of business may be of a confidential nature as a result of a communication with legal counsel. Those documents will be marked on each page: "CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGED COMMUNICATION—NOT FOR REDISCLOSURE." The legend will be placed away from margins where it could be lost in the duplication process. All efforts will be made to refrain from duplicating documents that are "Confidential" or "Attorney/Client Privileged."

5. All documents that are "Confidential" or "Attorney/Client Privileged" will be maintained separately in secured electronic files. The Compliance Officer or designee will maintain records of who may access the "Confidential" and "Attorney/Client Privileged" documents.

B. Miscellaneous Documents (maintained in the Corporate Compliance Department Google drive)

1. Names, titles, and background for the Compliance Officer and any compliance staff.

2. Names, titles, and backgrounds for any high-level individuals responsible for compliance functions.

3. Job descriptions for the Compliance Officer and any compliance staff.

4. Information regarding the reporting structure to the Corporate Compliance Committee and the AD.

5. Copies of reports made to the Corporate Compliance Committee and the AD.

C. Human Resource Documents (maintained in Human Resource Department files)

1. Human Resource and Compliance Policies and Procedures regarding the hiring of new personnel.

2. Documentation evidencing background checks performed on new hires.

3. Documentation reflecting individuals refused employment based upon background check findings.

4. Information collected during exit interviews regarding compliance issues.

D. Compliance Training Documents (maintained in the Corporate Compliance Department Google drive)

1. Information regarding the development and roll-out of the compliance training program.

2. Information regarding the development and implementation of specialized training for certain groups of personnel.

3. Attendance sheets from all training sessions performed.

4. Agendas and contents of training, including length of session and instructor.

5. Copies of all training handout materials.

6. Copies of all tests given.

7. Copies of all employee-signed acknowledgement documents relating to the Compliance Program.

E. Disseminated Compliance-Related Materials (maintained in the Corporate Compliance Google drive and the Communications Team files)

1. Copies of all notices sent to employees, subcontractors, and vendors regarding the Compliance Program, the Compliance hotline, and other compliance-related topics.

2. Copies of all newsletters and other Division publications that address the Compliance Program.

F. Monitoring and Auditing Materials (maintained in the Corporate Compliance Department Google drive)

1. Information regarding the number and frequency of all audits and documentation requirements.

2. Information regarding benchmarks and progress made.

3. Information regarding individuals responsible for conducting audits, if outsourced.

4. Information regarding the individuals that make up the audit team if audits are conducted internally.

5. Information describing the scope, type, and frequency of audits performed.

G. Documentation Related to the Program Integrity (PIU) hotline (maintained in the Corporate Compliance Department Google drive)

1. Promotional materials on the PIU hotline.

2. Logbook of reports of potential non-compliant behavior received via the PIU hotline and through other means of communication made to the Compliance Officer.

3. Documentation regarding fraud, waste, and abuse (FWA) and misconduct referrals, if necessary, on each report received.

4. Documentation of corrective action measures and imposed corrective action plans (CAP).

H. Misconduct Investigation Records (maintained in the Corporate Compliance Department Google drive)

1. Referral information stored in PIU database.

2. Copies of all Standards of Conduct and Misconduct Investigations reports.

I. Documentation Related to the Response to, and Prevention of, Detected Offenses

1. Reports on the investigations conducted into areas of potential noncompliance.

2. Reports on monitoring and oversight of CAPs.

3. Information regarding voluntary self-disclosures on noncompliance.

J. Government Contacts (maintained in the Corporate Compliance Department Google drive)

1. Log of all contacts made between the Division and any government authority including, but not limited to, AHCCCS, a fiscal intermediary or carrier, CMS, HHS, and the Officer of Inspector General. The log will include the name, title, and agency of the person spoken to, the date and time of the call, the matter referenced, and the response received from the individual along with information regarding the source of the response.

2. All correspondence to/from a government authority.

3. Documentation of any response to a request from a government authority for documents, including a summary of any investigation conducted by Corporate Compliance Team prior to responding.

6004-A QUALITY MANAGEMENT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-550, 36-595 et seq.; A.A.C. R6-6, R9-28, R9-33, R6-18; 42 CFR 438.66

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.

B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.

C. Oversight for determining quality, efficiency, and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division's contracted Health Plans; and oversight of a variety of services; and settings such as:

A. Assisted living facilities;

B. Individual's home (not contracted with the Division);

C. Day programs (Day Treatment and Training (child and adult));

D. Employment programs;

E. Nursing facilities;

F. Provider's home; or,

G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes).

6004-E OPERATIONAL REVIEWS

EFFECTIVE DATE: May 20, 2016
REFERENCES: 42 CFR Part 438, AHCCCS 1115 Waiver

Purpose of Operational Reviews

The purpose of the Division performing an Operational Review (OR) is to:

A. Know the Contractor's system and operation.

B. Support Contractor compliance with Division requirements.

C. Improve Contractor's compliance with Division requirements.

D. Recognize Contractor accomplishments.

E. Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with the Arizona Health Care Cost Control System (AHCCCS) 1115 Waiver.

F. Determine whether the Contractor satisfactorily meets:

1. Division contract requirements
2. Division policies
3. Arizona Revised Statute
4. Arizona Administrative Code
5. 42 CFR Part 438, Managed Care.

G. Determine progress made in implementing recommendations made during prior reviews.

H. Determine Contractor compliance with its own policies and procedures.

I. Evaluate the effectiveness of Contractor policies and procedures.

Types of Operational Reviews

The following are types of Operational Reviews:

A. Full Review, which includes a review of all standards

B. Focused Review, which includes review of specific:

1. Areas across all Contractors, e.g., implementation of value based purchasing
2. Standards related to individual Contractor performance.

Prior to Onsite Review Timeline

The timeline for performing Operational Reviews is as follows:

A. Three (3) weeks before onsite review, the Division provides formal notification of the onsite review to the Contractor.

B. Two (2) weeks before onsite review, the Contractor submits the first documents, which include Populations for Samples, e.g., Prior Approval (PA) Logs.

C. Within three (3) days of receipt of above documents, the Division notifies Contractor of which samples will be reviewed.

D. One (1) week before onsite review, the Contractor uploads all documents to the Division's File Transfer Protocol (FTP) site.

After Onsite Review Timeline

After the onsite review occurs, the following occur:

A. Six (6) weeks after the onsite review, the Division forwards a draft of its findings to the Contractor.

B. Within one week after above action, the Contractor may challenge The Division's finding by submitting a Challenge Letter to the Division.

C. Nine (9) weeks after the onsite review, the Division issues its Final Report.

D. Eleven (11) weeks after the onsite review, the Contractor Corrective Action Plan(s) (CAP) is due to the Division.

E. Six (6) months after the Division approves the CAP approval – CAPs must be completed and closed.

The Process – Document Review

The Division reviews documents at the Contractor's place of business (on-site), off-site, or a combination of both.

When the Division requests additional documents:

1. Before noon, the Contractor supplies the documents by close of business on the same day.

2. After noon, the Contractor supplies the documents by 9:00 a.m. on the following day.

OR Categories

OR Categories are:

A. Case Management (CM)

B. Claims and Information Systems (CIS)

C. Delivery Systems (DS)

D. General Administration (GA)

E. Grievance System (GS)

F. Maternal/Child Health and EPSDT (MCH)

G. Medical Management (MM)

H. Member Information (MI)

I. Quality Management (QM)

J. Reinsurance (RI)

K. Third Party Liability (TPL)

L. Corporate Compliance (CC).

6004-F COMPLIANCE PROGRAM

REVISION: 10/1/2019
EFFECTIVE DATE: June 10, 2016
REFERENCES: 42 CFR 438.230(b), 42 CFR 438.608, ACOM Policy 103

Compliance Program Overview

The Corporate Compliance Program consists of the development, maintenance, and implementation of compliance policies and procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Administrative Services Subcontractors, providers and agents) meet all legal and regulatory requirements in the performance of their duties.

The Program provides measures to prevent, detect and correct issues of non-compliance with applicable policies, federal and state regulations, and AHCCCS' contractual requirement to guard against fraud, waste and abuse (FWA).

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

A. 42 Code of Federal Regulation (CFR)

B. Health Insurance Portability and Accountability Act (HIPAA)

C. Arizona Revised Statutes (ARS)

D. Arizona Administrative Code (AAC)

E. The Division's Contract with the Arizona Health Care Cost Containment System (AHCCCS).

F. Centers for Medicare and Medicaid Services (CMS)

Definitions

A. Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary, or which fail to meet professionally recognized standards for health care.

B. Claim – Under the FCA, the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

C. Corporate Compliance Program – a formal program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations. It is designed, structured and implemented to correct identified compliance issues and assist the Division, providers, agents, and subcontractors in meeting legal, regulatory, and contractual obligations pertaining the services provided on behalf of the Division.

D. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

E. Deficit Reduction Act (DRA) –The DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government.

G. Governing Body – The Division as body of persons or officers who establishes the rules and policies, having the authority to exercise governance over its providers, agents and subcontractors.

H. Member – The eligible person enrolled to receive services with the Division.

I. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

J. Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

K. Prevention - Keep something from happening.

L. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

M. Waste - As defined by the Arizona Health Care Cost Containment System (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

Corporate Compliance Structure

The Corporate Compliance Program is designed to fulfill the Division's commitment to foster a culture of compliance and an environment conducive to preventing, detecting and correcting non-compliance issues with all applicable policies, federal and state laws and regulations, and AHCCCS contractual requirements. In addition, the Corporate Compliance Program provides guidance to Division staff, providers, agents and subcontractors in guarding against fraud, waste and abuse all levels of the organization.

The Corporate Compliance Committee monitors, reviews, and assesses the effectiveness of the Corporate Compliance program and the timeliness of reporting to ensure that the Corporate Compliance Program structure facilitates compliance with all legal and governmental requirements.

Corporate Compliance Committee members include:

- Assistant Director/Chief Executive Officer
- Corporate Compliance Office/Deputy Assistant Director
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

- The Chief Compliance Officer, Corporate Compliance Committee, and all other Division Management
- Human Resources Department
- All other Division employees.

Corporate Compliance Program Components

The Corporate Compliance Program is based on the seven key elements of Compliance that facilitate prevention, detection and remediation of non-compliance with federal and state laws and regulations, AHCCCS contractual requirements and DES-DDD internal policies and procedures. The seven key elements are:

1. Written Policies, Procedures and Standards of Conduct
2. Corporate Compliance Program Oversight
3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards
6. Monitoring and Auditing
7. Correcting Areas of Non-Compliance

The Corporate Compliance Program is centered on the Corporate Compliance Plan, compliance policies and procedures, oversight of compliance to law, and contractual obligations, education, monitoring, and enforcement. The Plan:

- Details the process and steps taken to prevent, detect, and remediate instances of non-compliance,
- Adheres to the Division's contract with AHCCCS,
- Is submitted annually to the AHCCCS Office of Inspector General (OIG).

A. Written Policies, Procedures and Standards of Conduct

The Corporate Compliance Program is based on written Policies, Procedures, and Standards of Conduct that facilitate compliance with federal and state laws, regulations, and AHCCCS contractual requirements.

Pursuant to the Deficit Reduction Act of 2005, written Policies address the Federal False Claims Act, administrative remedies for false claims/statements, civil and criminal penalties for false claims/statements, and whistleblower protections under law. See Operations Manual Policy 6002-N Fraud and False Claims, Provider Manual Chapter 20 Fraud, Waste and Abuse, and Provider Manual Chapter 21 False Claims Act.

B. Corporate Compliance Program Oversight

The Divisions Chief Compliance Officer and Corporate Compliance Committee provides Division-wide oversight to ensure compliance with Program and Fiscal Integrity. The Chief Compliance Officer is responsible for the strategy, implementation and oversight of the Division's Compliance Program.

The Corporate Compliance Program is structured to include Division staff responsible for the oversight of compliance related activities to include but not limited to:

1. Risk assessment and management of internal and external compliance
2. Development, implementation and/or monitoring of training and educational events for all Division staff, subcontractors, providers, and agents pertaining Corporate Compliance.
3. Provide technical assistance to all Division staff, subcontractors, providers and agents regarding compliance
4. Documentation of all referrals suspecting potential FWA or other issues of non-compliance
5. Development and monitoring of corrective action plans
6. Timely processing of referrals deemed credible of FWA and submission to AHCCCS OIG
7. Reporting to, and providing reports to, the Corporate Compliance Committee

C. Training and Education

1. Mandatory Training

a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:

i. Compliance
ii. Article 9
iii. HIPAA (annually)
iv. Standards of Conduct for State Employees
v. Fraud Awareness (annually)
vi. Business Continuity
vii. Diversity
viii. AHCCCS Overview

b. The Division trains employees as appropriate to their job functions, including but not limited to:

i. Support Coordination/Member Services

ii. Network/Provider Relations

iii. Medical Management

iv. Quality Management

v. Claims/Business Operations

c. The Division provides refresher training to all employees as appropriate to their job functions, and as needed

2. Training Materials

The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by the Corporate Compliance Unit.

3. Effective Lines of Communication

a. The Division provides updates to their personnel via the following formats:

i. Unit meetings/AMS

ii. Statewide meetings

iii. E-mails

iv. Echo Employee Newsletter

v. Policies and Procedures

b. The Division may provide updates to contracted providers in the following formats:

i. Provider/Coordination meetings

ii. Vendor Blasts/e-mails

iii. Policies and Procedure Manuals

iv. Contract monitoring units.

D. Enforcement of Standards

1. Evaluate the ability of prospective providers to perform the activities to be delegated, and using accepted risk assessment criteria, as needed.

2. Establish a written agreement (as defined by the Division's contract with AHCCCS) that:

a. Specifies activities and reporting responsibilities delegated to the contractor

b. Provides for revocation of such delegation, and application of sanctions

c. Includes other specific requirements, as stated in the Division's contract with AHCCCS.

3. Retain authority to direct delegated contract requirements

4. Communicate deficiencies to the provider so the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Monitoring/Auditing and Enforcement

1. The Division monitors compliance via:

a. Compliance-related reports based on Division and Provider/AdSS data,

b. Investigations of allegations of non-compliance,

c. Review of functional areas and related systems,

d. Assessment of mechanisms to facilitate prevention, detection and remediation of non-compliance,

e. Internal and external audits.

2. Reporting of Non-Compliance to the Division

The Division maintains open lines of communication to support Division personnel, subcontractors, providers, agents, members, and all other individuals in reporting non-compliance. Toll-free hotlines and dedicated email addresses are identified in Division publications and available on the Division website for this purpose.

3. Correcting Areas of Non-Compliance

Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:

a. May conduct a preliminary fact-finding to determine the nature of the incident,

b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases),

c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.

d. Responds to compliance issues to the extent required by law and within the mandated timeframes.

e. Enforces compliance and takes corrective actions as appropriate.

The Division generates regular compliance-related reports that include, but are not limited to:

a. Grievance System Report

b. Resolution System Report

c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims

d. Claims Dashboard

e. Encounters Report

f. Support Coordination Reports.

g. HIPAA violations report

6004-G Monitoring and Oversight

EFFECTIVE DATE: January 29, 2020

REFERENCES: 42 CFR 438.230(b); 42 CFR 438.608; ACOM 103; Operations Manual, Chapter 6000, Policy 6004.

This Policy stipulates requirements for the internal auditing, monitoring, and oversight of Long-Term Services and Supports (LTSS) provided by the Division, in accordance with the Division's Monitoring and Oversight Plan.

Definitions

A. Monitoring - The collection of data on a consistent basis as part of a plan to ensure contractual compliance and operational excellence.

B. Operational Area - Synonymous with business unit, functional area, or department within the Division.

C. Compliance Assurance Audit - A focused review of an operational area's compliance with contract requirements utilizing a standardized audit tool; the audit tool will include standards by which each business unit audited will be measured.

D. Key Performance Indicator (KPI) - A metric selected to provide quantifiable data in relation to the operational performance of a specific operational area or Business Unit

E. LTSS KPI Schedule of Annual Data Submissions - An overview of the KPI's collected from each operational area/Business Unit including the designated Subject Member Expert, frequency of data collection, and submission for each KPI required.

F. LTSS KPI Annual Data Submissions Template - The template provided by the Corporate Compliance Unit used by each operational area SME to collect and submit respective KPI's.

Monitoring and Oversight Plan Overview

The Monitoring and Oversight Plan has been developed as part of the Division's formal Corporate Compliance program. The plan implements a continuous, formal monitoring mechanism and compliance assurance auditing of various operational areas across the Division. The combined approach of monitoring and auditing aims to provide a preventive and corrective action approach that ensures compliance with AHCCCS contractual requirements and federal and state laws and regulations, while ensuring quality in operational and service delivery. Monitoring will be conducted across the Division's operational areas and will provide executive leadership an aggregated view of the organization's compliance health status.

A. Compliance Assurance Audits

A primary component of the Division's overall Monitoring and Oversight Plan is a system of compliance assurance auditing of each major LTSS operational area. Compliance assurance auditing will be performed by an internal auditing/monitoring business unit within the Corporate Compliance department in accordance with a planned schedule of focused audits throughout the year. The type, number, frequency, and timing of compliance assurance audits will be determined by the Compliance department leadership and approved by the Corporate Compliance Committee. Additionally, special, comprehensive audits of programs and operational areas will be

selected and conducted throughout the year by the Corporate Compliance team. The audits will focus on detecting and correcting fraud, waste and abuse; Health Insurance Portability and Accountability Act (HIPAA) violations; and risks to fiscal integrity but may also be a source of discovery that would identify a need for further compliance audits of specific operational processes.

B. Key Performance Indicators

Another key component of the Monitoring and Oversight Plan is a system of ongoing collection, compilation, and dissemination of Key Performance Indicators (KPI) across the Division's operational areas on a regular basis. KPI's were selected based on current internal, self-audit data, and AHCCCS contractual requirements and deliverables. Each operational area subject matter expert (SME) will be responsible for collecting and submitting designated KPIs on a consistent basis in accordance with the annual data submission schedule via the template provided by the Corporate Compliance Unit.

6005 - A COMPLIANCE PROGRAM CHARTER

EFFECTIVE DATE: July 1, 2020

REFERENCES: United States Sentencing Commission; *Federal Sentencing Guidelines*, Chapter Eight Effective Compliance Program, United States Department of Health and Human Services, Office of Inspector General.

The purpose is to oversee the Division's implementation of the compliance program, policies and procedures designed to address any identified regulatory risks facing the Division, and assist with the oversight responsibility for the Division's contractual and regulatory compliance, and standards of conduct.

The oversight responsibility of the Committee shall not extend to planning or conducting audits, conducting investigations, or assuring compliance with relevant laws, the Division's Code of Conduct, or other relevant standards, including those imposed by any resolution agreements such as corrective action plans, notice to cure or monetary sanctions. These are the responsibilities of the Division's Executive Leadership.

Definitions

Compliance Program - A compliance program is a set of internal policies and procedures within the Division to comply with laws, rules, and regulations, or contractual obligations. A compliance team examines the rules set forth by government bodies, creates a compliance program, implements it throughout the Division, and enforces adherence to it.

Elements of a Compliance Program - According to the Department of Health and Human Services-Office of Inspector General, an effective compliance program can enhance the Division's operations, improve quality of care, and reduce overall costs. There are seven fundamental elements of an effective compliance program:

- Policies and Procedures
- Oversight
- Education and Training
- Monitoring and Auditing
- Reporting
- Enforcement and Discipline
- Response and Prevention

Policy

Health care operates in a heavily regulated environment with a variety of identifiable risk areas; an effective Compliance Program can help mitigate those risks. Therefore, in the fulfillment of the Division's oversight responsibilities, management will be charged with the responsible of establishing a Compliance Program to help ensure that appropriate information as to AHCCCS contractual obligations, and all applicable state and federal laws

and regulations, will come to the attention of the Compliance Committee and Executive Leadership will be notified in a timely manner as a matter of ordinary operation.

A. The Division will establish a Compliance Committee to develop and maintain an effective Compliance Program.

B. A Compliance Officer will be appointed with the delegated authority to manage the Compliance Program's day-to-day operation.

C. The Compliance Officer and designees will ensure that the Compliance Program includes the seven elements that make an effective compliance program.

D. An annual risk assessment will be completed for the Division. Identified potential risk areas will be evaluated periodically, and reported to the Assistant Director and the Compliance Committee.

E. A report of Compliance Program activities will be presented periodically to the Assistant Director and the Compliance Committee.

F. The Compliance Committee will conduct an annual self-assessment of the Compliance Committee's activities.

6005 B - COMPLIANCE INVESTIGATION

EFFECTIVE DATE: July 1, 2020

REFERENCES: Corporate Compliance: Guide to Conducting Workplace Investigation

The purpose of this policy is to ensure prompt and appropriate investigation of compliance concerns and allegations.

Definition

Internal Investigation – An investigation of any concerns or allegations within an organization. The concerns or allegations for the Compliance Officer or designee to investigate may include but are not limited to, any allegations or complaints regarding non-Medicaid related fraud, waste, and abuse of the program and misconduct.

Investigation Requirements

A. All investigations begin with a review of submitted concerns or allegations.

B. There should be a thorough review of any documentation and information that is involved in the investigation. It may include an audit of billing practices and corrective actions, if necessary. The Division should cease all of the contributing factors that may be the cause of the non-compliance, as appropriate.

C. Interviews with a participating individual(s) are as follows:

1. The interview includes the “Who, What, When, Where, and Why” of the circumstances.

2. All interview notes and document notes reviewed shall be kept as part of the investigation file.

D. The Division initiates Corporate Compliance in-services and training if necessary, to the appropriate departments or individuals involved.

E. The results of the investigation are the last components in the file. As a result of the investigation, the Compliance Officer or Designee may include a corrective measure with the referral to bring the issue into compliance. The referral is sent to the DDD Employee Relations and DES Internal Affairs. However, based on findings from the investigation, the Corporate Compliance Team may review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered. When the investigation is completed, the results will be filed in its designated file.

1. The Compliance Officer or designee summarizes the investigation, corrective actions, if applicable, and procedures that are put in place to prevent the non-compliance circumstances from recurring.

2. If the Compliance Officer or designee investigates an alleged violation and believes the integrity of the investigation may be at stake because of the presence of employee(s) under investigation, Division shall remove the

individual(s) involved from current responsibilities until the investigation is completed.

6006 AHCCCS DELIVERABLE SUBMISSION REQUIREMENTS

EFFECTIVE DATE: June 28, 2023

PURPOSE

The purpose of this policy is to outline the requirements of the Division staff when reviewing and submitting deliverables to AHCCCS. This policy applies to any Division staff responsible for receiving deliverables from the subcontracted health plans or completing an AHCCCS contract or ad hoc requests deliverable.

POLICY

A. DELIVERABLES RECEIVED FROM THE DIVISION'S SUBCONTRACTED HEALTH PLANS

Responsible Assigned Division staff shall follow AHCCCS Deliverable Submission Requirements and Administrative Services Subcontractor Compliance Monitoring procedures when completing a deliverable submission or response to AHCCCS involving engagement with the subcontracted health plans.

B. AHCCCS DELIVERABLE SUBMISSION

1. The Division shall complete accurate and timely deliverable submissions to AHCCCS.

2. Assigned Division staff shall follow AHCCCS Deliverable Submission Requirements procedure and submit accurate and complete deliverables to AHCCCS in accordance with the established due date.
3. Division staff shall ensure a backup plan is in place for all contract deliverables by providing training to the identified accountable staff member.

C. The Division's Operational Compliance shall assign a corrective action plan to the functional area if any of the requirements in this policy are not met.

7001 PRIVACY INCIDENT AND BREACH NOTIFICATION

EFFECTIVE DATE: January 18, 2023
REFERENCES: 45 CFR § 164.402; 45 CFR § 164.404; 45 CFR § 164.410; 45 CFR § 164.408, 45 CFR § 164.412; 45 CFR § 164.502; 45 CFR § 164.530; A.R.S. § 12-2297

PURPOSE

This policy applies to all Division of Developmental Disabilities (Division) staff. It describes the process the Division follows when a privacy incident occurs.

DEFINITIONS

1. "Breach" means an impermissible use or disclosure of Protected Health Information (PHI) unless the Covered Entity or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Breach excludes:
    a. Any unintentional acquisition, access, or use of PHI by the Division's Workforce or a person acting under the authority of a Covered Entity or Business Associate if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further

use or disclosure in a manner not permitted under the Health Insurance Portability and Accountability Act (HIPAA).

b. Any inadvertent disclosure by a person who is authorized to access PHI at a Covered Entity or Business Associate to another person authorized to access PHI at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.

c. A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

2. "Business Associate" means a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a Covered Entity.

3. "Covered Entity" means health plans, health care clearinghouses, and health care providers who electronically transmit any health information in connection with transactions for which Health and Human Services (HHS) has adopted standards.
4. "Protected Health Information (PHI)" means individually identifiable health information about a member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.
    b. Relates to the:
        i. Past, present or future physical or mental health condition of a member;
        ii. Provision of health care to a member; or
        iii. Payment for the provision of health care to a member.

PHI excludes information in:

a. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
b. Records described at 20 USC 1232g(a)(4)(B)(IV);
c. Employment records held by a Covered Entity in its role as an employer; or
d. Regarding a person who has been deceased for more than 50 years.

5. "Workforce" means employees, volunteers, trainees, and other persons under the direct control of the Covered Entity, whether or not they are paid by the Covered Entity.

POLICY

A. DISCOVERY OF A BREACH

1. The Division shall treat a Breach as discovered as of the first day on which such Breach is known to the Division or, by exercising reasonable diligence, would have been known to the Division or any person, other than the person committing the Breach, who is part of the Division's Workforce or an agent of the Division.

2. Anyone in the Division's Workforce who believes that member information has been used or disclosed in any way that compromises the security or privacy of that information shall immediately notify the Division's Privacy Compliance Unit by completing the Division's online form.

3. Following the discovery of a potential Breach, the Division's Privacy Compliance Unit under the guidance of the Health Information Manager shall:

   a. Begin an investigation;

   b. Conduct a risk assessment; and

   c. Based on the results of the risk assessment, begin the process of notifying each member whose PHI has been, or is reasonably believed by the Division to have been, accessed, acquired, used, or disclosed as a result of the Breach.

B. BREACH INVESTIGATION

1. The Division's Privacy Compliance Unit shall be responsible for the:

a. Management of the Breach investigation,

b. Completion of the risk assessment,

c. Coordination with others in the Division as appropriate, and

d. Facilitation of all Breach notification processes.

2. Anyone in the Division's Workforce involved in the privacy incident shall assist the Division's Privacy Compliance Unit in the investigation and provide information as requested.

C. RISK ASSESSMENT

1. The Division shall presume an impermissible use or disclosure of PHI is a Breach unless the Division's Privacy Compliance Unit performs a risk assessment and the results demonstrate a low probability that the PHI has been compromised.
2. The Division's Privacy Compliance Unit shall complete a thorough risk assessment in good faith and the conclusions should be reasonable.
3. The Division shall include the following factors in a risk assessment:

a. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

b. The unauthorized person who used the PHI or to whom the disclosure was made;

c. Whether the PHI was acquired or viewed; and

d. The extent to which the risk to the PHI has been mitigated.

4. The Division's Privacy Compliance Unit shall consider the factors listed above in subsection C(3), or more, to determine the overall probability that PHI has been compromised.

5. Based on the outcome of the risk assessment, the Division's Privacy Compliance Unit shall determine the need to move forward with Breach notification.

6. The Division's Privacy Compliance Unit shall document the risk assessment and the outcome of the risk assessment process.

D. NOTIFICATION

1. Notice to member

a. If a Breach of PHI has occurred, the Division's Privacy Compliance Unit shall notify the affected member(s) without unreasonable delay and in no case later than 60

days after the Breach is discovered. "Unreasonable delay" means action based on a lack of good faith or justifiable reasons for the delay.

b. The Division shall ensure the notice is written in plain language and includes the following to the extent possible:

   i. A brief description of what happened,

   ii. A description of the types of information affected,

   iii. Steps that affected members should take to protect themselves from potential harm resulting from the Breach,

   iv. A brief description of what the Division is doing to investigate, mitigate, and protect against further harm or Breaches.

c. The Division's Privacy Compliance Unit shall notify the member as follows:

   i. Unless otherwise authorized by the member, by first class mail to the member's last known address.

   ii. If agreed to in writing by the member, by email.

iii. In the form of one or more mailing as information becomes available.

d. If the Division lacks sufficient contact information to provide direct written notice by mail to the member, the Division's Privacy Compliance Unit shall use a substitute form of notice reasonably calculated to reach the member.

i. If there is insufficient contact information for fewer than 10 affected members, the Division's Privacy Compliance Unit shall provide notice by telephone, email, or other means.

ii. The Division's Privacy Compliance Unit shall document if the Division lacks sufficient information to provide any such substitute notice.

iii. If there is insufficient contact information for 10 or more affected members, the Division's Privacy Compliance Unit shall do one of the following after consulting with the Department of Economic Security (DES) Chief Privacy Officer:

1) Post a conspicuous notice on the homepage of the Division's website for 90 days with a hyperlink to the additional information required to be given to members as provided above, or

2) Publish a conspicuous notice in major print or broadcast media in the area where affected members reside. The notice shall include a toll-free number that remains active for at least 90 days so members may call to learn whether their PHI was Breached.

e. The Division's Privacy Compliance Unit shall provide immediate notice to the member by telephone or other means if they believe that PHI is subject to imminent misuse. Such notice shall be in addition to the written notice described above.

2. Notice to next of kin for a deceased member

a. If the member is deceased and the Division knows the address for the member's next of kin or personal representative, the Division's Privacy Compliance Unit shall

mail the written notice described above to the next of kin or personal representative.

b. If the Division does not know the address of the next of kin or personal representative, the Division is not required to provide any notice to the next of kin or personal representative.

c. The Division's Privacy Compliance Unit shall document the lack of sufficient contact information.

3. Notice to Health and Human Services (HHS)

a. In the event a Breach of unsecured PHI affects 500 or more of the Division's members, the Division's Privacy Compliance Unit shall coordinate with the DES Chief Privacy Officer to ensure HHS will be notified.

b. If fewer than 500 of the Division's members are affected, the Division's Privacy Compliance Unit shall maintain a log of the Breaches to be submitted to the DES Chief Privacy Officer annually.

4. Delay of notification authorized for law enforcement purposes for notices made to members, the media, HHS, and by the Division's Business Associates

   a. If a law enforcement official states in writing that a notification, notice, or posting would impede a criminal investigation or cause damage to national security and specifies the time for which a delay is required, the Division's Privacy Compliance Unit shall delay for the time period specified by the official.

   b. If a law enforcement official states orally that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the Division's Privacy Compliance Unit shall:

      i. document the statement, including the identity of the official making the statement; and

      ii. delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

E. MAINTENANCE OF BREACH INFORMATION

1. The Division's Privacy Compliance Unit shall maintain a process to record or log all Breaches of unsecured PHI, regardless of the number of members affected.

F. WORKFORCE TRAINING

1. The Division shall ensure that everyone in the Workforce is trained on the Division's policies and procedures with respect to PHI as necessary and appropriate to carry out their job responsibilities.
2. The Division shall ensure that everyone in the Workforce is trained how to identify and report Breaches within the Division.

G. SANCTIONS

1. The Division shall refer anyone in the Workforce who fails to comply with this policy to the Program Integrity Unit and/or Human Resources for disciplinary action.

H. RETALIATION/WAIVER

1. The Division shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any member for exercising his or her privacy rights.

2. The Division shall not require members to waive their privacy rights as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

7002 AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.502 and 45 C.F.R. § 164.508

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. It outlines the process for the authorization for use and disclosure of Protected Health Information (PHI) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that

conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives members rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Payment" means the same as in 45 CFR 164.501.
6. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

7. "Responsible Person" means the same as in A.R.S. § 36-551.

8. "Treatment" means the same as in 45 CFR 164.501.

9. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

10. "Psychotherapy Notes" are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record.

POLICY

A. AUTHORIZATIONS

1. Uses and disclosures for which authorization is required.
    a. The Division shall develop an authorization form in writing and in plain language.
    b. The Division shall not require the Member to use the Division's authorization form.
    c. The Division's Privacy Officer and Records Manager shall determine whether an authorization form that was not

developed by the Division contains all of the required elements, as stated per the HIPAA Privacy Rule.

d. If a determination could not be reached, the Division's Privacy Officer and Records Manager shall consult the Attorney General's Office for additional guidance before disclosing protected health information based on that authorization.

B. VALID AUTHORIZATION CORE COMPONENTS

1. The Division shall verify that an authorization form contains the following components:
   a. A description of the information to be used or disclosed;
   b. The name or other specific identification of the Member or class of persons authorized to make the requested use or disclosure;
   c. The name or other specific identification of the Member or class of persons to whom the Division shall make the requested use or disclosure;
   d. A description of each purpose of the requested use or disclosure;

e. The statement "at the request of the Member" is a sufficient description of the purpose when a Member initiates the authorization and does not, or elects not to, provide a statement of the purpose;

f. An expiration date or an expiration event that relates to the Member or the purpose of the use or disclosure;

g. The signature of the Member and date;

h. If the authorization is signed by a personal representative of the Member, a description of such representative's authority to act for the Member, including a copy of the legal court document, if any, appointing the personal representative.

C. REQUIRED ADDITIONAL AUTHORIZATION INFORMATION

1. The Division shall ensure that the authorization form contains a statement informing the Member of their right to revoke the authorization at any time and how the Member may revoke the authorization.

2. The Division shall:

a. Not require the Member to sign an authorization as a condition of eligibility for benefits, enrollment in a health plan or the provision of treatment or payment; and

b. Make a statement on the authorization form to that effect.

3. Notwithstanding the requirement in subsection (2) of this section:

a. The Division may condition services to a Member on a signed authorization for the use or disclosure of protected health information for research purposes prior to providing research-related treatment.

b. The Division shall require a Member to sign an authorization if the information needed will determine the Member's eligibility, and the authorization does not include the use or disclosure of psychotherapy notes.

c. The Division shall require a Member to sign an authorization form before providing health care services unless otherwise approved by the Division as creating an impediment to the health and well-being of the Member.

D. INVALID AUTHORIZATION

1. The Division shall consider an authorization invalid if:
    a. The expiration date has passed or the expiration event is known by the Division to have occurred;
    b. The authorization form has not been filled out completely as to the core elements outlined in this policy;
    c. The authorization has been revoked;
    d. An authorization that states eligibility for benefits, enrollment in a health plan or treatment or payment of an authorization is a required condition, except as outlined in this policy;
    e. The authorization is a compound authorization, requesting information from separate and distinct sources that require separate authorizations, such as psychotherapy notes along with other protected health information;
    f. The Member did not voluntarily sign the disclosure form or was coerced into signing the authorization form; or
    g. Any material information in the authorization is known to be false.

E. The Division shall give a copy of the authorization to the Member upon request and maintain a copy in the Member's case file.

7003 MINIMUM NECESSARY STANDARD FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

REVIEW DATE:

EFFECTIVE DATE: December 27, 2023

REFERENCES: 45 C.F.R. § 164.502; 45 C.F.R. § 164.512

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. The purpose of this policy is to outline the requirements for making reasonable efforts to limit the use and disclosure of protected health information (PHI) as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Business Associate" means the same as in 45 CFR § 160.103.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information and applies to health plans,

health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.

5 Minimum Necessary Standard" means the same as referenced in 45 CFR § 164.514(d)(2)(i)(A).

6. "Payment" means the same as in 45 CFR 164.501.

7. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:

   a. Created or received by a:

i. Health care provider,

ii. Health plan,

iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

8. "Treatment" means the same as in 45 CFR 164.501.

POLICY

A. The Division shall limit unnecessary or inappropriate access to PHI:

1. Through the provision of healthcare services and related healthcare operations;
2. When it is required by law to be disclosed for an audit, for health oversight and public health; and
3. For use in court or administrative law proceedings.

B. The Division shall ensure the following utilizing the Minimum Necessary Standard:

1. Uses or disclosures for treatment, payment, and health care operations (TPO);
2. Uses or disclosures requiring the member to have an opportunity to agree or object;
3. Uses or disclosures that are permitted without the Member's authorization; and

4. Uses or disclosures by Business Associates if they are not for the reasons outlined in section (D) of this policy.

C. The Division shall disclose only the PHI necessary to accomplish the intended purpose of the use, disclosure, or request by:

1. Identifying persons or classes of persons who need access to the PHI to accomplish their job responsibilities, and
2. Establishing protocols that reasonably limit access to PHI.

D. The Division shall not utilize the Minimum Necessary Standard for the following:

1. Disclosures or requests by a health care provider for treatment.
2. Disclosures to a Member who is the subject of the PHI.
3. Uses or disclosures made pursuant to a Member's authorization on a HIPAA-compliant form.
4. Uses or disclosures required for compliance with HIPAA standard transactions.
5. Uses or disclosures required by the U.S. Department of Health and Human Services (DHHS) except when the Division has been required to provide PHI to DHHS for enforcement purposes.

6. Uses or disclosures that are required by law.

7004 ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

REVIEW DATE:

EFFECTIVE DATE: December 13, 2023

REFERENCES: 45 C.F.R. § 164.528

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy establishes the Division's requirements for the accounting of Disclosures of Protected Health Information (PHI) required by the Health Information Portability and Accountability Act of 1996 (HIPAA) as outlined in 45 CFR 164.528.

DEFINITIONS

1. "Business Associate" means the same as in 45 CFR § 160.103.
2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
3. "Health care operations" means the same as in 45 CFR 164.501.
4. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes

national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,

ii. Health plan,

iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

7. "Payment" means the same as in 45 CFR 164.501.

8. "Responsible Person" means the same as in A.R.S. § 36-551.
9. "Treatment" means the same as in 45 CFR 164.501.

POLICY

A. The Division shall provide the Member the right to receive an accounting of Disclosures of certain Protected Health Information (PHI).

B. The Division shall only accept an accounting of Disclosure when requested by the Responsible Person in writing.

C. The Division shall track the following types of PHI Disclosures:

1. Disclosures to a public health authority as permitted by law;
2. Disclosures to health oversight agencies as permitted by law, including government agencies that oversee the health care system, government benefits programs requiring health information, or other government regulatory programs;
3. Disclosures required by law, including court rules, administrative and court orders, statutes or agency rules, administrative and court subpoenas, or other lawful process;
4. Disclosures to Business Associates that are not exempt under section (D) of this policy;

5. Disclosures made in error or in violation of the law that are not exempt from accounting; and
6. Disclosures to law enforcement.

D. The Division shall not track the following PHI for accounting purposes:

1. Disclosures to carry out treatment, payment, and health care operations;
2. Disclosures to the Member who is the subject of the Protected Health Information;
3. Disclosures incidental to those permitted by the privacy rules;
4. Disclosures pursuant to a HIPAA-compliant authorization;
5. Disclosures to others involved in a Member's care or for disaster relief when the Member had an opportunity to agree or object;
6. Disclosures made for national security or intelligence purposes as provided in the regulations;
7. Disclosures to correctional institutions or law enforcement officials having custody of a Member if the Disclosure of the PHI is for treatment, the health and safety of other inmates, the health and safety of law enforcement staff, or the administration of the correctional institution; and

8. Disclosures when made as a limited data set.

E. The Division shall temporarily suspend a Member's right to an accounting of Disclosures of PHI to a health oversight agency or law enforcement agency under the following circumstances:

1. When the Division receives an oral request by the agency or entity for a suspension, the Division's Privacy Officer shall ensure it is documented:
   a. That an accounting to the Member would likely impede the Division's activities;
   b. The length of time of the suspension is not to exceed 30 days from the date of the oral statement, unless a written statement providing the time limit is submitted during the 30 days;
   c. The identity of the person in the agency or entity making the statement and the agency or entity represented; and
   d. That the right to an accounting is temporarily suspended.
2. When the Division receives a written, dated request for a suspension of an accounting, the Division's Privacy Officer shall ensure that the following is documented:

a. The name and identifying information of the Member who is the subject of the accounting;

b. A statement that such an accounting to the Member would be reasonably likely to impede the agency or entity activities;

c. The time for which such a suspension is required;

d. The official letterhead of the agency or entity requesting the suspension; and

e. The signature and title of the person representing the authorized agency that is requesting the suspension.

F. The Division shall account for Disclosures of PHI that occurred during the six years prior to the request for an accounting if the accounting is not past the retention period for documentation of the accounting for the Disclosure.

G. The Division's Privacy Officer shall provide a written response to a request for an accounting that contains:

a. Date of Disclosure of PHI;

b. Name of the entity or person who received the PHI;

c. Address of the entity or person, if known;

d. A brief description of the PHI disclosed; and

e. A brief statement of the purpose of the Disclosure that reasonably informs the Member of the basis for the Disclosure, or in lieu of such a statement, and a copy of the written request for Disclosure.

H. If, during the period covered by the accounting, the Division has made multiple Disclosures of PHI to the same person or entity for a single purpose, the Division shall ensure the accounting of Disclosure contains:

a. The information in section (G) of this policy;

b. The frequency, periodicity, or number of Disclosures made during the accounting period; and

c. The date of the last such disclosure during the accounting period.

I. After receipt of the written accounting request, the Division shall either:

1. Provide the accounting requested; or

2. If the Division cannot provide the accounting within the 30-day timeframe provide a one-time 30-day extension letter in writing that provides:
   i. An explanation of the delay, and
   ii. The date by which the accounting will be provided.

J. The Division shall maintain documentation of the Accounting for the Disclosure in the Member's case file and retain the documentation for six years from the date of the entry.

7005 RIGHT TO REQUEST RESTRICTION OF USES AND DISCLOSURES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.522

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the requirement when a Member requests a restriction of uses and disclosures, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Designated Record Set" means a group of records maintained by the provider that contains the following:
    a. Medical and billing records maintained by a provider,
    b. Case and medical management records, or
    c. Any other records used by the provider to make medical decisions about the Member.
2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.

3. "Health care operations" means the same as in 45 CFR 164.501.
4. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Payment" means the same as in 45 CFR 164.501.
7. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is

transmitted or maintained in any medium where the information is:

a. Created or received by a:
    i. Health care provider,
    ii. Health plan,
    iii. Employer, or
    iv. Health care clearinghouse.

b. Relates to the:
    i. Past, present, or future physical or mental health condition of a Member;
    ii. Provision of health care to a Member; or
    iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:
    i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
    ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a Member who has been deceased for more than 50 years.

8. "Responsible Person" means the same as in A.R.S. § 36-551.

9. "Treatment" means the same as in 45 CFR 164.501.

10. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. The Division shall give Members the right to request a restriction of the uses and disclosure of their Protected Health Information (PHI) under the following circumstances:

1. For treatment, payment, or health care operations; and
2. To family members, other relatives, or any other person identified by the Member who may be directly involved in the Member's care and for notification purposes.

B. The Division's Privacy Officer shall determine if the request will be accepted or denied based on the requirements of the Privacy Rule.

C. Notwithstanding the provision of section (A) of this policy, the Division shall not require the Division's Privacy Officer to agree to the restriction of the use and disclosure of PHI.

D. The Division shall advise the Responsible Person of the following:

1. If the Member is applying to another agency for benefits, restricting the disclosure of PHI may result in a delay or denial of benefits.
2. By restricting which providers can receive PHI may limit the services that can be provided by the Division.
3. If the restriction is agreed-upon, any use or disclosure by the Division contrary to the agreed restriction would be a violation of the Privacy Rule.

E. RESTRICTED RECORDS DISCLOSED FOR EMERGENCY TREATMENT

1. The Division shall request that the health care provider receiving the PHI shall not further use or disclose the information.
2. The Division shall document this request to the provider in the Member's designated record set.

F. The Division shall not restrict PHI when that information is:

1. Required for investigations by the Secretary of the Department of Health and Human Services (DHHS).
2. Required by law.
3. Required for emergency treatment, unless the Member has expressly advised that they do not want treatment.

G. TERMINATION OF RESTRICTION ON USE OR DISCLOSURE

1. The Division shall terminate or modify an agreement to a restriction if:
   a. The Responsible Person agrees to or requests termination or modification in writing;
   b. The Responsible Person orally agrees to the termination and the oral agreement is documented; or
   c. The Division informs the Member that it is terminating the agreement to a restriction with respect to the PHI created or received after the Division has informed the Member.

H. The Division's Privacy Officer shall provide a response to the request for restriction to the Member in writing within 30 days and maintain the response in the designated record set.

7007 RIGHT TO RECEIVE ALTERNATIVE MEANS OF COMMUNICATION FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.522 and 45 C.F.R. § 164.502

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the Member's right to request privacy protection utilizing alternative means of communication.

DEFINITIONS

1. "Designated Record Set" means a group of records maintained by the provider that contains the following:
    a. Medical and billing records maintained by a provider,
    b. Case and medical management records, or
    c. Any other records used by the provider to make medical decisions about the Member.

2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.

5. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:

   a. Created or received by a:

      i. Health care provider,

      ii. Health plan,

      iii. Employer, or

      iv. Health care clearinghouse.

   b. Relates to the:

      i. Past, present, or future physical or mental health condition of a Member;

      ii. Provision of health care to a Member; or

      iii. Payment for the provision of health care to a Member.

   c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

6. "Responsible Person" means the same as in A.R.S. § 36-551.

POLICY

A. The Division shall allow the Responsible Person the right to request an alternate means of communication and an alternative address to receive communication of Protected Health Information (PHI).

1. The Division shall condition on the provision of a reasonable accommodation on:

a. When appropriate, information as to how payment, if any, will be handled; and

b Specification of an alternative address or other method of contact.

2. If a Member clearly indicates in the request for an alternative means of communication that disclosure of the PHI would put them in danger, then the Division shall make the accommodation.

B. The Member shall make the request for, and describe, the alternative means of communication or alternative location in writing.

1. The Division's Privacy Officer shall grant or deny the request based on 45 C.F.R. § 164.522 and 45 C.F.R. § 164.502.

2 The Division's Privacy Officer shall maintain all documentation regarding the request and whether the request is granted or denied in the designated record set.

C. The Division shall allow the Responsible Person to request the Division to send electronic PHI (ePHI) in an unencrypted format.

D. If the Responsible Person requests to receive PHI in an unsecured email transmission, prior to using an unsecure email transmission to provide PHI, the Division shall:

1. Inform the Responsible Person of the risk of unsecured email transmissions, and
2. Require the Responsible Person to acknowledge in writing the risk of unsecured email transmissions when transmitting PHI.

E. The Division shall review requests for an unencrypted transmission on an annual basis and maintain all documentation identified, reviewed, or involved in the request, in the case records.

7008 NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 3/13/2024

REFERENCES: 45 C.F.R. § 164.520

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the requirements for the Notice of Privacy Practices (the Notice) of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that

conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

6. "Payment" means the same as in 45 CFR 164.501.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental

disability who is a member or an applicant for whom no guardian has been appointed.

8. "Treatment" means the same as in 45 CFR 164.501.
9. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. The Division shall provide the Notice of Privacy Practices (the Notice) to Members receiving services from the Division annually and upon request.

B. The Division shall ensure the Notice:

1. Outlines the Uses and Disclosures of Protected Health Information (PHI),
2. Notifies the Member of their rights regarding PHI, and
3. Notifies the Member of the Division's legal duties with respect to PHI.

C. The Division shall Use or Disclose PHI in a manner consistent with the Notice.

D. The Division shall ensure the Notice is written in plain and simple language that Members, employees, or personal representatives can easily read and understand.

E. The Division shall promptly revise the Notice whenever there is a material change to:

1. The Uses or Disclosures,
2. The Member's rights,
3. The Division's legal duties, or
4. Other privacy practices stated in the Notice.

F. Except when required by law, the Division shall not implement a material change to any term of the Notice prior to the effective date of the material change.

G. The Division shall ensure the Notice of Privacy Practices contains:

1. The following statement as a header or otherwise prominently displayed:

   "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

2. A description of the types of Uses and Disclosures that the Division is permitted to make for treatment, payment, and health care operations and include at least one pertinent example.
3. A description of all other purposes for which the Division is permitted or required to Use or Disclose PHI without the Member's written authorization.
4. A statement that if a Use or Disclosure for any purpose is prohibited or significantly limited by another applicable law, the description of such Use or Disclosure shall reflect the more stringent law.
5. A statement that other Uses and Disclosures will be made only with the Member's written authorization and that the Member may revoke such an authorization at any time.
6. A statement of the Member's rights with respect to PHI and a brief description of how the Member may exercise these rights, as follows:

a. The right to request restrictions of certain Uses and Disclosures of PHI, including a statement that the Division is not required to agree to a requested restriction.

b. The right to receive communications of PHI confidentially.

c. The right to inspect and copy PHI.

d. The right to request an amendment to PHI.

e. The right to receive an accounting of applicable Disclosures of PHI; and

f. The right of a Member, including an individual who has agreed to receive the Notice electronically, to obtain a paper copy of the Notice from the Division upon request.

7. A statement that the Division is required by law to maintain the privacy of PHI.

8. A statement of the Division's legal duties and privacy practices with respect to PHI.

9. A statement that the Division shall abide by the terms of the Notice currently in effect.

10. A statement that the Division reserves the right to change the terms of the notice and how it will provide a revised notice, along with the date the Notice goes into effect.
11. A statement that the Member has a right to file a complaint with the Division Privacy Officer, including their name and telephone number, and with the Secretary of the Department of Health and Human Services if a Member believes their privacy rights have been violated.
12. A statement that the Member will not be retaliated against if they file a complaint.

H. The Division shall document compliance with the Notice requirements by retaining copies of the Notices issued by the Division and, if applicable, any written acknowledgments of receipt of the Notice or documentation.

7009 DE-IDENTIFICATION - PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: February 28, 2024

REFERENCES: 45 C.F.R. § 164.502; 45 C.F.R. § 164.514

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the de-identification of protected health information as required by the Health Insurance Portability and Accountability Act of 1996 "HIPAA".

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule

requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

3. "Member" means the same as "client" as defined in A.R.S. § 36-551.
4. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.
    b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

6. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. DE-IDENTIFIED PHI IS CREATED BY REMOVING IDENTIFIERS

1. The Division shall determine when Protected Health Information (PHI) is subject to de-identification by ensuring all of the identifiers defined as PHI are removed from the documents regarding the Member.
2. The Division shall ensure that the following identifiers of the Member, the Member's relatives, employers, or individuals living in the same household, are removed from the documents:
    a. Names
    b. All geographic subdivisions smaller than a State, including:
        i. Street address,
        ii. City,
        iii. County,
        iv. Precinct,
        v. Zip code, and

vi. Their equivalent geocodes.

c. All elements of dates, except year for dates directly related to an individual, including:

i. Birth date,

ii. Admission date,

iii. Discharge date,

iv. Date of death, and

v. All elements of dates that identify an individual to be age 90 or older are aggregated into a single category.

d. Telephone numbers.

e. Fax Numbers.

f. Electronic mail addresses.

g. Social Security Numbers.

h. Medical record numbers.

i. Health plan beneficiary numbers.

j. Account numbers.

k. Certificate/license numbers.

l. Vehicle identifiers and serial numbers, including license plate numbers.

m. Device identifiers and serial numbers.

n. Web Universal Resource Locators (URLs).

o. Internet Protocol (IP) address numbers.

p. Biometric identifiers, including finger and voice prints.

q. Full face photographic images and any comparable images.

r. Any other unique identifying number, characteristics, or code that can be re-identified.

B. ACTUAL KNOWLEDGE THAT INFORMATION CAN BE USED TO IDENTIFY AN INDIVIDUAL

1. If the Division has actual knowledge that any information remaining after de-identification could be used alone or in combination with other information to identify the Member, then the Division shall consider the information to be individually identifiable and not use or disclose without proper authorization.
2. If an employee of the Division has knowledge of any remaining identifiable information, the employee shall consult with the Division's Privacy Officer prior to releasing the information.

C. CODED DATA

1. The Division shall assign a code to health information or use some other similar means of identifying PHI to allow otherwise de-identified information to be re-identified provided that:
    a. The code or other means of identification do not come from or are related to the Member's identifying information.
    b. The code shall not be capable of being translated so as to identify the Member by an outside entity.
2. The Division shall document the codes in writing and record all analyses and information used to re-identify health information.
3. The Division shall not use or disclose the code or other means of record identification for any other purpose, and shall not disclose the mechanism for re-identification.

100-D DEFINITIONS

REVISION DATE: 5/24/2021, 7/3/2015, 9/1/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36- 29, 36-553, 36-2901, 36-2904, 36-2931, 36-3401; A.A.C. R9-22-101, R6-6-903, R9-22-1201(w).

1115 Waiver – The 1115 Waiver refers to section 1115 of the Social Security Act (SSA). States must comply with Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the SSA. Since Arizona began providing Medicaid on October 1, 1982, the Arizona Health Care Cost Containment System (AHCCCS) has been exempt from specific provisions of the SSA, pursuant to an 1115 Research and Demonstration Waiver. The 1115 Waiver specifies provisions in the SSA and corresponding regulations AHCCCS is exempt from; terms and conditions that AHCCCS must fulfill; and approved federal budget amounts. (Arizona Section 1115 Demonstration Project Waiver).

Arizona Administrative Code (A.A.C.) - The Arizona Administrative Code is a publication of the official rules of the State of Arizona. Rules are adopted by state agencies, boards or commissions, with specific rulemaking authority from the State Legislature. Rule sections are published in Titles and Chapters.

Arizona Developmental Disabilities Planning Council (ADDPC) –The ADDPC works to support advocacy, bring about systems change and create increased capacity to support persons with developmental disabilities in the community. The ADDPC was established pursuant to Public Law 106-402, also known as the Developmental Disabilities Assistance and Bill of Rights Act of 2000. Pursuant of an Executive Order by the Governor of the State of Arizona on September 3, 2009, the Council was created. Council members are appointed by the Governor of Arizona.

Arizona Health Care Cost Containment System (AHCCCS) – The single State Medicaid agency, as described in A.R.S. § Title 36, Chapter 29, Arizona Medicaid Agency. AHCCCS is composed of the AHCCCS Administration, Contractors and other arrangements through which health care services (acute, long-term care, and behavioral) are provided to members.

Arizona Long Term Care System (ALTCS)- An AHCCCS program which delivers long term, acute, behavioral health care, and case management services as authorized by A.R.S. § 36-2931 *et seq*, to eligible members who are either elderly and/or have physical disabilities and to members with developmental disabilities, through contractual agreements and other arrangements.

Arizona Long Term Care System (ALTCS) Contractor- A contracted managed care organization (also known as a Program Contractor), that provides long term care, acute care, behavioral health and case management services to Title XIX eligible individuals who are either elderly and/or who have physical or developmental disabilities who are determined to be at immediate risk of institutionalization.

Arizona Revised Statute (A.R.S. §) - Laws of the State of Arizona.

Assistant Director Approval – Includes approval from the Assistant Director's designee.

Centers for Medicare and Medicaid Services (CMS) – An organization within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).

Code of Federal Regulations (CFR) - The general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Comprehensive Health Plan (CHP) - The Comprehensive Health Plan (CHP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CHP.

Contractor - An organization, person, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. § 36-2904 to provide goods and services to members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and federal law and regulations.

Developmental Disabilities Advisory Council (DDAC) – Advisory Council to the Division of Developmental Disabilities whose duties have been established by A.R.S. § 36-553 whose voting members are also appointed by the Governor of Arizona.

Direct Care Worker – A person who assists individuals with activities necessary to allow them to reside in their home. These workers may also be known as Direct Support Professionals.

Durable Medical Equipment (DME) – An item or appliance that is not an orthotic or prosthetic; is designed for medical purpose; is generally not useful to a person in the absence of an illness or injury; can withstand repeated use; and, is generally reusable by others.

Durable Medical Equipment (DME), Customized - Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

Fee-For-Service (FFS) - A method of payment to an AHCCCS registered provider on an amount-per-service basis.

Focus – The automated web-based system used to maintain information on each member eligible for the Division.

Home and Community Based Services (HCBS) - Services provided, in lieu of institutionalization, to ALTCS members who reside in their own home or in an ALTCS approved home and community based alternative residential setting in order to maintain the member's highest level of functioning. Members enrolled in the ALTCS Transitional Program also receive HCBS.

Home Program – The Home Program provides for specific activities for the member to do with their families/caregivers during the course of their daily activities to enhance progress towards the chosen treatment goals.

Human Rights Committee (HRC) – This Committee provides independent oversight to monitor and ensure the civil and human rights for persons with developmental disabilities as guaranteed in the U.S. Constitution, federal law regulations, and the Arizona Revised Statutes.

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Medically Necessary - As defined in A.A.C. R9-22-101, medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.

Member – A person enrolled with the Division of Developmental Disabilities.

Planning Document – A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Individualized Support Plan (ISP), and Person Centered Plan (PCP).

Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Prior Authorization (PA) – Process by which the Division approves a service.

Program Review Committee (PRC) – As defined in agency rules at A.A.C. R6-6 903, the PRC is an assembly designated by the District Program Manager that reviews any behavior treatment plans which meet the criteria also outlined in the same rules. The PRC approves plans, or makes recommendations for changes as necessary.

Regional Behavioral Health Authority (RBHA) – As defined in A.R.S. § 36-3401, the RBHA is an organization under contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to administer covered behavioral health services in a geographically specific service area of the state. Tribal governments, through an agreement with the ADHS/DBHS, may operate a Tribal Regional Behavioral Health Authority (TRBHA), as defined in A.A.C. R9-22-1201(w), for the provision of behavioral health services to American Indian members living on-reservation. Through an intergovernmental agreement with ADHS/DBHS, the Division is responsible for all behavioral health services provided to members eligible for ALTCS.

Service Plan Year – The annual period of time beginning at the member's "ISP Start Date" as identified in Focus through the "ISP End Date" as identified in Focus.

Title XIX - Known as Medicaid, Title XIX of the Social Security Act provides for federal funds to the states for medical assistance programs.

200 BEHAVIORAL HEALTH PRACTICE TOOLS

210 WORKING WITH THE BIRTH THROUGH FIVE POPULATION

EFFECTIVE DATE: May 4, 2022

REFERENCES: AMPM Chapter 200, A.R.S. §13-3620, A.A.C. R9-20-205

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and the system of care for behavioral health services for members enrolled with Medicaid. This policy is an optional resource for the Tribal Health Program; it is not a requirement. The policy is designed to strengthen the capacity of Arizona's Behavioral Health System in response to the unique needs of children age birth through five and emphasizes early intervention through the use of clinical assessment, service planning and treatment, all of which focus on identification of situations that may potentially impede infants'/toddlers' ability to:

1. Form close parent/caregiver relationships with those in the child's environment (these may be long term or temporary, familial, or non-familial),
2. Experience, regulate and express their emotions, and
3. Explore their environment in an accessible manner.

DEFINITIONS

Assessment (Behavioral Health) means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM). A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona

Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the AdSS and the role of Support Coordination. While the Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this practice tool, the Division remains responsible for case management (Support Coordination) and oversight of the AdSS. Support Coordination shall receive training on the practices outlined in this tool for purposes of increasing their ability to coordinate services for their members. The Division shall conduct formal oversight of the AdSS.

Refer to AdSS Medical Policy 210 for the roles and responsibilities of the AdSS and their subcontracted network, and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management, and other clinical services.

B. TARGET POPULATION(S)

All Division members birth through five years of age (up to age six), who are ALTCS eligible and are receiving behavioral health services, in collaboration with their caregivers.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

The promotion of behavioral health in infants and toddlers is critical to the

prevention and mitigation of mental disorders throughout the lifespan. Over the past decade, the research has demonstrated mounting evidence pointing to the detrimental impact that early, negative childhood experiences can have on the developing brain. A well-known example of that research is a study conducted by a California Health Maintenance Organization. This longitudinal study, known as the ACES study (Adverse Early Childhood Experiences), showed a positive correlation between frequency of negative early childhood events (e.g., neglect, violence, trauma) and development of physical and behavioral health challenges in adulthood. The more negative events that occurred during early childhood, the more adults tended to have physical and behavioral health conditions in adulthood such as depression, alcoholism, obesity, and heart disease. Although the ACES study points to the negative impact of adverse early childhood experience, the field of infant behavioral health has promulgated the knowledge in intervention techniques designed to mitigate negative effects of early abuse, trauma, or violence.

Early childhood experiences can build strong foundations or fragile ones and can affect the way children react and respond to the world around them for the rest of their lives. The early social and emotional development of infants and toddlers is vulnerable to factors, such as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance exposure. Without intervention, these risk factors can result in behavioral health disorders including depression, attachment disorders, and traumatic stress disorders, which can have an effect on later school performance and daily life functioning.

Children who have been maltreated are at an increased risk for behavioral health concerns, poor psychological adaptation and lifelong health difficulties. Children entering the child welfare system have higher rates of exposure to traumatic events with most victims of child abuse and neglect being under the age of five. Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of

trauma.

1. An effective approach to promoting healthy social and emotional development shall include equal attention to the full continuum of behavioral health services including promotion, prevention, and treatment, plus improvement in system capacity for effective service delivery. Essential components of a comprehensive system include:

    a. Supporting the use of evidence-based early childhood service delivery models,

    b. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals, and

    c. Improving access to services.

    Untreated behavioral health disorders can have disastrous effects on children's functioning and future outcomes. Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma. Behavioral Health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth, and constipation, as well as overall delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdrawal from social interaction.

    Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) can predict subsequent aggressive behavior. Some early behavioral health disorders have lasting effects and may appear to be precursors of behavioral health problems later in life. Early signs and symptoms of behavioral health disorders may include withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and trauma stress reactions.

    Increasingly, young children are being expelled from childcare and preschool

for behavior problems, including biting, tantrums, hitting, throwing objects, or inconsolable crying. Even if they do remain in a program, young children with behavioral concerns are challenging to teach and quickly lose motivation for learning. Additionally, they may withdraw from their peers or face social rejection.

Healthy social-emotional development is strongly linked to success in elementary school. Children who are not secure in relating to others and do not trust adults are not motivated to learn. Furthermore, children who are unable to respond to calming influences initiated by themselves or others will not be responsive to teaching methods or benefit from their early educational experiences and may lag behind their peers.

2. Parent's behavioral health can affect young children. Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond as parents with an untreated mental disorder are less able to provide developmentally- appropriate stimulation and parent-child interactions. Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence, and maltreatment. Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school. Although these sources cite maternal depression as a factor, these effects can also be attributed to relationships the young child has with other primary caregivers.

   Increased training in early childhood behavioral health is necessary and essential. In-depth knowledge of child development systems and multi-disciplinary approaches, as well as possession of diagnostic and clinical skills are critical components for professionals who assess and treat young children. Additionally, practitioners need to acquire and demonstrate a range of interpersonal skills in their work in order to build individualized, respectful,

responsive, and supportive relationships with families. These skills include:

a. The ability to listen and observe carefully,

b. Demonstrate concern and empathy,

c. Promote reflection,

d. Observe and highlight the child-parent/caregiver relationship,

e. Respond thoughtfully during emotionally intense interactions, and

f. Understand, regulate, and use one's own feelings.

Scientific advances in neurobiology have provided birth through five practitioners with greater insight into the complex system of the brain. The development of the central nervous system begins with the formation of the neural tube, which nears completion by three to four weeks of gestation and is the basis for all further nervous system development. Genes determine when specific brain circuits are formed, and each child's experiences then shape how that formation develops. Stable and responsive relationships along with proper sensory input through hearing and vision are what build healthy "brain architecture". Thus, the most important relationships begin with the child's family and extend outward to other adults important in that child's life such as day care and educational providers.

3. Empirical evidence has shown that young children are greatly impacted by their early development and experiences. By understanding how specific events impact a young child's brain function, the behavioral health professional is able to formulate individualized interventions. Therefore, it is incumbent upon all practitioners to become educated about brain development, functions of various parts of the brain and their role in the physical and emotional development of the child. Some additional resources in the area of brain development include:

a. "Brain Facts, A Primer on the Brain and Nervous System" through the Society for Neuroscience,

b. "Starting Smart, How Early Experiences Affect Brain Development,"

c. "From Neurons to Neighborhoods: The Science of Early Childhood Development," and

d. C.H. Zeanah, Jr., (Ed.). (2009). Handbook of Infant Toddler Behavioral Health.

D. METHODOLOGY

In an ongoing effort to improve the delivery of behavioral health services in an effective and recovery-oriented fashion, the Arizona Vision, as established by the Jason K. Settlement Agreement in 2001, implemented the use of the Child and Family Team (CFT) practice model and the 12 Arizona Principles, both of which strongly support the critical components of behavioral health practice with children birth through five and their families. Infant and Early Childhood Behavioral Health practice integrates all aspects of child development such as organic factors (genetics and health) with the child's experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

The nature and pace of these changes, as well as the preverbal nature of this young population present the behavioral health professionals with uniquely complex challenges. It is crucial for children to rely on the knowledge of the parents/ caregivers and the expertise of a multidisciplinary team of professionals to provide them with information when conducting behavioral health evaluations, developing service plans, and implementing clinical interventions. Qualified professionals shall have an understanding of the correct use and interpretation of screening, assessment, and evaluation tools and processes, plus how to use these results for service planning and implementing clinical interventions.

1. Assessment and treatment of children age birth through five is based on the philosophical orientation that work is done on behalf of the child, predominantly through the child's parent or caregiver(s). Child development takes place within the context of the caregiving relationship, which is strongly influenced by child characteristics, parent/caregiver characteristics, and

perhaps most importantly the unique match or "fit" between a child and the child's caregivers. It is important that trained personnel:

a. Have comprehensive knowledge of early childhood development,

b. Possess excellent observational and relationship-building skills with children and adults,

c. Be able to identify resources and needs within the family/caregiving environment, and

d. Communicate assessment results in a comprehensible and accessible manner to parents/primary caregivers and other professionals.

2. For children who are ALTCS eligible and are under the custody of Department of Child Safety (DCS) and are being served by an AdSS who are referred through the Rapid Response process, it is important for the behavioral health provider to consider a full range of services at the time of removal. Multiple Division policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:

a. Division Operations Policy 417,

b. Division Operations Policy 449,

c. Division Medical Policy 310-B

d. Division Medical Policy 320-O, and

e. Division Medical Policy 541.

As part of the assessment process, ongoing evaluation of the child after the initial removal is needed to assess the child's physical appearance, areas of functioning, the child's relationships, and adjustment to the new environment. If the child is placed with a different caregiver, re-assess again to monitor the child's adjustment to the new setting. When assessing children involved with DCS who are showing delays which can be due to the trauma of removal, neglect, or abuse, determine if a referral for additional trauma

informed care services or any other type of assistance is needed. Refer to AMPM 210 Attachment A for use with children living in a kinship placement, DCS resource parents (foster or adoptive), or congregate care (shelter or group home). Additional information outlining special considerations for providing services to infants, toddlers and preschool-aged children involved in the child welfare system can be accessed through: "The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS" (refer to AMPM Behavioral Health Practice Tool 260).

II. ESSENTIAL PROCESSES FOR ASSESSMENT, SCREENING AND SERVICE PLANNING

Evaluation practices with respect to children age birth through five involve awareness on the part of the behavioral health practitioner that all children have their own individual developmental progression, affective, cognitive, language, motor, sensory and interactive patterns. All children age birth through five are participants in relationships, with the child's most significant relationships being those with their primary caregiver(s). A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of the child's most significant relationships. This is best done over several sessions, in different settings (e.g., home, childcare, clinic), and whenever possible with all significant caregivers. In order to support a child in demonstrating the child's true capacities, screening and assessment processes are most effectively offered in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and that reflect their daily life experiences. Identification of all significant caregivers and the child's relationship with each individual is a critical part of assessment practice.

A. DEVELOPMENTAL SCREENING

Division eligible children undergo developmental screening prior to enrollment with the Division. Refer to Division Medical Policies 430 and 541 for details. In addition, when a child aged birth to five is receiving behavioral health services, screening for sensory, behavioral, and developmental concerns continues as an ongoing process that organizes continuous observations regarding the needs, challenges, strengths

and abilities of the child and parent/caregiver. Screening or testing instruments become part of comprehensive assessment practice, are intended to be used for the specified purpose they were designed for, shall be reliable and valid, and are not to be used in isolation to render a diagnosis.

The use of AMPM 210 Attachment B provides assessors and caregivers with a set of dimensional milestones (e.g., movement, visual, hearing, smell, touch, speech, social and emotional, language, cognitive, hand and finger skills), as well as growth and developmental "red flags". As part of the assessment process for infants and young children, developmental checklists establish a baseline to which subsequent screenings during the course of treatment can be compared. Developmental checklists provide opportunities to assess the degree to which children are meeting developmental milestones. Should there be delays in meeting standard developmental milestones, it may be necessary to refer to the child's PCP for further evaluation. For children three to five, a referral to the public school system may be more appropriate. The various professionals supporting the child and family shall plan and communicate to avoid duplication of screening services. Multiple developmental screening tools are available. Some are suggested directly within this document and others are provided as attachments to AMPM 210. These tools are available as accompaniments to this Practice.

B. ASSESSMENT CONSIDERATIONS

It is essential that behavioral health practitioners continually evaluate their screening and assessment tools because the practice of infant and early childhood behavioral health is dynamic and continually changes due to improved technology and newly developed research techniques, strategies, and results. While the Division does not require the use of a specific assessment tool, minimum elements have been established that shall be included in any comprehensive behavioral health assessment as specified in Division Medical Policy 320-O. Refer to AMPM 210 Attachment C, as one example of an assessment tool for children age birth through five. Additional options for assessments specific to children birth through five, are included as AMPM 210 attachments.

1. There is no single tool that encompasses the full range of social, emotional,

and developmental skills and challenges that can occur in young children. The following tools and resources can provide additional information when assessing developmental milestones, behavioral, emotional, and social concerns, trauma and attachment:

a. Ages and Stages Questionnaire (ASQ): developmental and social-emotional screening for children aged one month to five and ½ years,

b. Hawaii Early Learning Profile (HELP): curriculum-based assessment covering regulatory/sensory organization, cognitive, language, gross and fine motor, social and self-help areas for children birth to three years, separate profile available for three- to six-year-old children,

c. Infant-Toddler Social-Emotional Assessment (ITSEA©): measures social-emotional and behavioral domains for children one to three years of age,

d. Connor's Early Childhood Assessment: aids in the early identification of behavioral, social, and emotional concerns and achievement of developmental milestones for children two to six years of age,

e. Parents' Evaluation of Developmental Status (PEDS): evidence-based screening of developmental and behavioral concerns for children birth to eight years, and

f. Trauma-Attachment Belief Scales (TABS™): measure cognitive beliefs about self and others for parents/caregivers age 17 and older to assist with identifying possible trauma history and its potential impact on the attachment relationship between the parent/caregiver and the child.

Considerable skill is required in the administration of the assessment process, integration of the data obtained from the assessment, and development of initial clinical conceptualizations and intervention recommendations. Refer to Technical Assistance Paper No. 4, "Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs" for further information on other resources and test reviews of

screening and assessment instruments.

Assessment with children age birth through five is a specialty area that requires specific competencies. Competent providers recognize the limitations of their knowledge and scope of practice. When necessary, they make use of the expertise of more experienced behavioral health practitioners, as well as the range of disciplines that address questions related to early development (e.g., pediatrics, speech/language therapy, occupational therapy, physical therapy) through collaboration, consultation, and referral practices.

2. Behavioral Health Assessment practice with children age birth through five typically involves:

   a. Interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories,

   b. Direct observation of family functioning,

   c. Gaining information, through direct observation and report, about the child's individual characteristics, language, cognition, and affective expression,

   d. Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,

   e. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/ learning, and to help regulate emotions,

   f. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship, and

   g. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, behavioral health, parenting, legal, educational, domestic violence, military).

Division Medical Policy 310-B and Division Medical Policy 320-O provide additional information on the types of behavioral health providers that may conduct assessments.

C. DIAGNOSTIC CONSIDERATIONS

The diagnostic process consists of two aspects: the classification of disorders and the assessment of individuals. In classifying disorders, practitioners are able to communicate with one another about descriptive syndromes using universal terms and language. The diagnostic process is ongoing rather than a one-time "snapshot" of symptoms. Behavioral Health practitioners collect information over time in order to understand multiple aspects of the presenting concerns, as well as variations in adaptation and development that are revealed on different occasions within various contexts.

It is suggested that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the Diagnostic Classification of Behavioral Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-5). This diagnostic manual, which draws on empirical research and clinical practice that has occurred worldwide since the manual was first published in 1994 as the DC: 0-3 and revised in 2016. The DC: 0-5 is designed to help behavioral health and other professionals recognize behavioral health and developmental challenges in young children, understand how relationships and environmental factors contribute to behavioral health and developmental disorders, use diagnostic criteria effectively for classification and intervention, and work more effectively with parents and other professionals to develop effective service plans. The updated version provides clear and specific criteria for all diagnostic categories. Examples include:

1. Criteria for identifying autism spectrum disorders in children as young as 2, introduces.
2. New criteria for disorders of sleep, eating, relating, and communicating.
3. Clarifies the Parent-Infant Relationship Global Assessment Scale (PIRGAS).
4. Checklists for identifying relationship problems, psychosocial and

environmental stressors.

Copies of the DC: 0-5 manual are available through the Zero to Three Press. This manual contains the DC: 0-5 codes that correspond to DSM-5 codes, as well as the ICD-10 codes.

D. ANNUAL ASSESSMENT UPDATE

While assessment is an ongoing process that offers new information throughout the continuum of service delivery, a formal assessment update shall be completed on an annual basis, or sooner, if there has been a significant change in the child's/family's status. A child's response to treatment might be affected by significant events or trauma that have occurred since the last assessment/update, such as changes in the child's living environment, childcare arrangements, death of a primary caregiver, as well as medical/developmental conditions and hospitalizations. Input from the family/ caregiver, as well as observation(s) of the child in conjunction with a review of the clinical record, provides the information necessary for summarizing their response to treatment and progress toward meeting goals over the past year.

A review of the child's current level of functioning would include updating information related to the child's emotional and behavioral regulation, quality of the parent-child interaction, relationships with caregivers/significant others, living environment, family stressors, safety concerns, and stability of home/relationships. Developmental screening as part of the annual update, and during the course of treatment, will assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral.

E. SERVICE PLANNING CONSIDERATIONS

1. Use of CFT Practice

   The early development of an engaged relationship with the child, parent/ caregiver, and family as part of the CFT process, is required practice when working with children age birth through five. This critical work directly involves the entire family, and it is the family that guides the therapeutic process. Refer to the Child and Family Team Practice Tool on the AHCCCS website under Guides - Manuals – Policies – AMPM Chapter 200. This Practice

Tool provides additional information on the specific components and the required service expectations of this practice model.

Infants and young children benefit from planning processes that support the inclusion of the following components:

a. Ongoing and nurturing relationships with one or two deeply attached individuals,

b. Physical protection, safety and regulation at all times,

c. Experiences suited to individual differences to include regular one-to-one interaction between the caregiver and child,

d. Developmentally appropriate experiences (e.g., one-to-one interaction that encourages an emotional dialogue that fosters a sense of self, problem solving, communication skills and a sense of purpose),

e. Limit setting, structure and expectations (e.g., clear messages and routines), and

f. Stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral concerns and/or developmental delays. An essential part of the therapeutic process is to help reduce this social isolation. Encouraging the exploration of natural supports can spur a family to begin thinking differently about their support system(s).

Whenever possible, the utilization of natural environments for clinical intervention is recommended. If the natural environment is not a conducive setting due to a lack of privacy, site of traumatic event for the child/parent and/or safety concerns, alternative settings need to be considered with input from the family. In addition to location, natural environments also include

the everyday routines, relationships, activities, people and places in the lives of the child and family. health, right, and safeguards

2. Community Collaboration

Starting with the assessment process, intervention strategies incorporate information from all involved providers serving the child, parent, or caregiver. This may include healthcare, childcare, and early intervention providers, the parent's/caregiver's behavioral health provider(s), as well as friends and extended family that are important in the family's life. Examples of several early intervention providers include Head Start/Early Head Start, the Arizona Early Intervention Program, Early Childhood Education through the Arizona Department of Education, and the Division of Developmental Disabilities. These individuals, if the parent/caregiver wishes, then become part of the Child and Family Team who will develop an effective service plan that employs natural supports in conjunction with formalized services (Refer to Division Medical Policy 220 Child and Family Team). The size, scope and intensity of team member involvement are determined by the objectives established for the child and needs of the family in providing for the child.

In order to make informed referrals as part of the service planning process it is imperative that behavioral health professionals and technicians (BHPs & BHTs) who work with children age birth through five and their families, become familiar with community services and programs that serve young children, as well as the local school district programs for children three to five years of age. At minimum, BHPs and BHTs should have familiarity with AzEIP, Head Start, Division of Developmental Disabilities, ADHS Office of Children with Special Health Care Needs, First Things First, and school district services that may be available for children eligible for preschool.

If at any time throughout the assessment, treatment delivery, or service planning processes a behavioral health practitioner believes that a child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a duty to report that belief to a peace officer or DCS per A.R.S. §13-3620. Behavioral Health staff is to consult with their supervisor if

they are unclear about their duty to report a situation.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication, and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For non-enrolled children who are not Medicaid eligible, coordination and communication should occur with any known health care provider. Refer to Division Medical Policy 211 for additional information on the use and coordination of psychotherapeutic and psychopharmacological interventions.

Documentation in the clinical record is required to show the communication and coordination of care efforts with the health care provider related to the child's behavioral health treatment (refer to Division Medical Policy 320-O and 940).

F. SERVICE PLAN DEVELOPMENT

1. While a comprehensive and accurate assessment forms the foundation for effective service planning and is required before a service plan can be fully developed, needed services should not be delayed while the initial assessment process is being completed. In addition to consideration of clinical disorders, findings from a comprehensive assessment of children birth through five years of age should lead to preliminary ideas about:

    a. The nature of the child's pattern of strengths and difficulties, risk, and protective factors,

    b. Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,

    c. Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns, etc. to the child's

competencies and difficulties, and

d. How the service planning process will address these areas.

Service plans should be strength-based in addressing needs and whenever possible draw upon natural supports. For young children, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.

A comprehensive and intensive approach to service planning would include attention to those factors that place young children's healthy attachment and social-emotional development at risk. Critical planning includes interventions that address a parent's/caregiver's behavioral health concerns and how these may affect the ability of that parent/caregiver to interact with and respond sensitively to the child's emotional and physical needs. Prematurity, low birth weight and conditions associated with prenatal substance exposure may require specific interventions when they affect the early social and emotional development of infants and toddlers.

Service planning also needs to address a child's ability to form close parent/ caregiver relationships. These relationships can be undermined by traumatic events such as repeated exposure to violence, abuse, or neglect, or when children experience multiple caregiver changes. When the child/family has multi-agency involvement, every effort should be made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. Additionally, planning should address collaboration with early intervention service providers and early education programs. This is especially important for those children who are experiencing expulsion from childcare or preschool settings due to behavioral concerns.

The use of all service settings, the full array of covered services, and skilled, experienced providers are to be considered as identified by the Child and Family Team during the service planning process. Service planning that includes the use of Support and Rehabilitative Services is often an essential

part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community (refer to AMPM 230).

All service plan development with children age birth through five is completed collaboratively with the child's parent or primary caregiver. Development and prioritization of service plan goals are not focused solely on the child. It is essential to include the parent, caregiver, and the needs of the family as a whole. Due to the age of the birth through five population and the rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives. At the time of the Annual Update, the service plan should be modified to align with the needs identified in the updated Assessment. Refer to Division Medical Policy 320-O for further information on the minimum elements for Assessments, Service Plans, and required timeframes for completion.

2. Clinical Practice

The guiding principle in the practice of infant and early childhood behavioral health is to "do no harm". Clinical intervention assumes a preventative, early intervention treatment focus based on sound clinical practice, delivered in a timely and accessible manner across all settings, and implementation in accordance with the Arizona Vision and 12 Principles. Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.

a. Infant and early childhood therapeutic approaches are supported by the following conceptual premises:

i. The child's attachment relationships are the main organizer of the child's responses to danger and safety in the first five years of life,

ii. Emotional and behavioral problems in early childhood are best

addressed within the context of the child's primary attachment relationships, and

iii. Promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.

b. The following skills and strategies are fundamental to the work of infant and early childhood behavioral health:

i. Building relationships and using them as instruments of change,

ii. Meeting with the infant and parent/caregiver together throughout the period of intervention,

iii. Sharing in the observation of the infant's growth and development,

iv. Offering anticipatory guidance to the parent/caregiver that is specific to the infant,

v. Alerting the parent/caregiver to the infant's individual accomplishments and needs,

vi. Helping the parent/caregiver to find pleasure in the relationship with the infant,

vii. Creating opportunities for interaction and communication exchange between parent/caregiver(s) and infant or parent/caregiver(s) and practitioner,

viii. Allowing the parent/caregiver to take the lead in interacting with the infant or determining the agenda or topic for discussion,

ix. Identifying and enhancing the capacities that each parent/ caregiver brings to the care of the infant,

x. Wondering about the parent/caregiver's thoughts and feelings

related to the presence and care of the infant and the changing responsibilities of parenthood,

xi. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent,

xii. Listening/observing for the past as it is expressed in the present, inquiring, and talking,

xiii. Allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing, and talking about them as the parent is able,

xiv. Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant's development, the parent/caregiver's emotional health and the early developing relationship,

xv. Attending and responding to the infant's history and early care within the developing parent/caregiver-infant relationship,

xvi. Identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness and family dysfunction, and

xvii. Remaining open, curious and reflective.

While all the skills and strategies noted above are pertinent in working with children and families, item "xi" through "xvii" are of unique importance to the practice of the infant and early childhood behavioral health practitioner. These seven strategies address the emotional health and development of both the parent/caregiver and the child. The practitioner focuses on past and present relationships and the complexities many parents/caregivers encounter when nurturing, protecting, and responding to the emotional needs of their children. Within this context, the practitioner and parent/caregiver

may think deeply about the care of the young child, the emotional health of the parent/caregiver, the many challenges of early parenthood, and the possibilities for growth and change.

3. Clinical Approaches

Information obtained through the assessment process will guide infant and early childhood trained practitioners in determining which intervention(s) is most conducive in meeting the needs of the young child and the child's family. More than one approach may be utilized and integrated into the service plan.

Support is the most basic intervention, where behavioral health personnel function as a resource to assist primary caregivers in accessing community resources, such as housing, employment, childcare, health services and food. Emotional support may also be provided to families when they are faced with a crisis related to the care of their child(ren). This support can be shown by the clinician's attention to the expressed concerns of the caregiver, acknowledgement of the caregiver's needs and strengths, and showing empathy in response to the situation. Support and Rehabilitation services can also assist with reducing the family's distress so that they are able to focus on the care requirements of their young child.

Advocacy can take the form of helping caregivers in expressing their needs and navigating systems of care. It can be challenging for clinicians to know when and how to speak effectively on behalf of young children and their families, especially those who may be involved with the child welfare system.

Developmental Guidance provides information to the primary caregiver(s) on a young child's abilities, developmental milestones and needs, as well as practical caretaking guidance that may be delivered individually or in a group format. Within the therapeutic environment, the clinician can offer opportunities to the caregiver to enhance positive interaction and playful exchange with the child. These exchanges, if based on the child's developmental needs, reinforce what the caregiver is able to do with the child

and may promote a mutually pleasurable experience and purposeful response at the child/caregiver relationship level.

Relational Guidance helps primary caregivers to increase their knowledge of and experience with their infant or young child through spontaneous interactions. Caregivers are taught how to attend to their child's distinctive cues with clinicians modeling parenting behavior. When using guided interaction strategies, clinicians can then provide feedback directly or review videotapes with the caregiver.

The following two approaches to therapy focus on the relationship between the primary caregiver and the infant. *Child-parent psychotherapy* offers the opportunity for thoughtful exploration with the caregiver of the child's ideas about parenthood and the continuing needs of the infant or toddler. The clinician assists the primary caregiver in gaining access to repressed early experiences, re-examining the feelings associated with them and achieving insight into how these experiences may affect the caregiver's capacity to be responsive to the infant. Relational difficulties with the infant may take the form of a caregiver's inability to hold or feed their baby, set limits that are appropriate in keeping young children safe, or interacting and communicating in ways that will arouse the child's curiosity. The infant is included as a catalyst for change, with the clinician guiding the caregiver to interact in a different way with their infant. A second approach, *child-parent dyadic therapy*, reflects the perspective that infants contribute to relationships and holds that the infant is able to use the time therapeutically for him/herself, similarly to the caregiver.

Attachment theory based in part on John Bowlby's *internal working model*, proposes that early experiences with the parent or primary caregiver forms the basis of memory patterns or "internal working models" that influence behaviors for other social relationships. Interventions are consistent with attachment theory if they include the following elements:

a. Provide emotional and physical access to the mother/caregiver,

b. Focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals,

c. Place the mother/caregiver in a non-intrusive stance,

d. Provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver, and

e. Provide a clinician who functions as a secure base for the dyad.

Developmental approaches to therapy offer an alternative to the traditional behavioral approach. Modalities under this approach can provide a framework for understanding and organizing assessment and intervention strategies when working with children with developmental delays and behavioral health concerns.

Reference materials on infant and early childhood mental health practice have been provided as a supplemental resource. This resource list is not meant to be exhaustive, given that research and clinical practice in this area continue to evolve.

G. TRAINING AND SUPERVISION RECOMMENDATIONS

Behavioral Health over the past several decades, has experienced significant advances in the understanding of early child development and the effects of trauma on early brain development. The need to have providers with trained expertise in this area has risen dramatically and is well recognized nationally and in Arizona. AHCCCS is focused on efforts in several areas to build workforce expertise and availability of services to children age birth through five and their families.

H. WORKFORCE DEVELOPMENT

The Infant and Toddler Behavioral Health Coalition of Arizona (ITMHCA) has adopted the Michigan Association for Infant Behavioral Health Endorsement® for Culturally Sensitive, Relationship-Based Practice Promoting Infant Behavioral Health. Endorsement® recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family field. This endorsement® model

describes the areas of expertise, responsibilities, and behaviors that demonstrate competency and verifies that professionals have attained a specified level of understanding and functioning linked to the promotion of infant behavioral health. Of additional importance, endorsement provides an organized approach to workforce development that identifies competency- based trainings and reflective supervision experiences that enhance confidence and credibility among infant, toddler and family clinicians (Behavioral Health Professionals), as well as other professionals who work with this population (Behavioral Health Technicians/Behavioral Health Paraprofessionals). While competency-based training and reflective supervision supports behavioral health practitioners who work primarily with young children and their families, this expertise may also be applied to professionals working with adults with a serious mental illness or substance use concerns who are parenting their own infants/toddlers.

It is recommended that provider agencies have practitioners endorsed as appropriate to the mission of the agency. Endorsement® through the ITMHCA includes four levels of competency:

1. Level 1: Infant Family Associate - Individuals who possess Child Development Associate (CDA), or academic degree, or two years of infant and early childhood related paid work experience; recommended for childcare or respite workers.

2. Level 2: Infant Family Specialist - Bachelor's, Master's or Doctoral (e.g. Social Work, "Applied" studies, nursing, behavioral health related) degree and a minimum of two years' work related experience with infants/toddlers and families; recommended for behavioral health staff involved in service planning and delivery such as case management and peer/family support, support and rehabilitation service provider personnel, parent educators, childcare consultants, and DCS workers.

3. Level 3: Infant Behavioral Health Specialist - Masters, MSN (Nursing), PhD, PsyD, EdD, M.D. or D.O. with two years post-graduate work and training in infant, early childhood, and family fields; recommended for behavioral health

clinicians and supervisors, infant behavioral health specialists, clinical nurse practitioners, psychologists, and early intervention specialists. Reflective Supervision is required.

4. Level 4: Infant Behavioral Health Mentor - (Clinical, Policy, or Research/ Faculty) Individuals at the mastery level (Master's, Postgraduate, Doctorate, Post Doctorate, MD or DO) qualified to train other professionals; recommended for infant and early childhood program supervisors, administrators, policy specialists, and physicians/psychiatrists.

Endorsement information and application materials are available through the local Infant Toddler Behavioral Health website: Infant Toddler Behavioral Health Coalition of Arizona (www.itmhca.org).

I. TRAINING

This Practice Tool applies to the Division and their subcontracted network and provider agencies, including the behavioral health staff that provide direct service delivery to children age birth through five and their families. Behavioral health practitioners working with this population (children age birth through five) require specialized training. Professional development in the area of infant and early childhood behavioral health is necessary at all levels of the Behavioral Health System, along with the personnel of service systems that interface with behavioral health professionals, such as DCS, the Division, AzEIP, and other community-based early intervention programs.

Behavioral Health practitioners seeking increased knowledge in this area are encouraged to attend infant and early childhood behavioral health trainings that include:

1. A multidisciplinary approach that is strengths-based.
2. Effective interviewing, communicating and observational techniques.
3. Assessment of parent-infant relationships.
4. Screening and diagnostic measures for infants and toddlers.

5. Early childhood development.
6. Effects of early adverse experiences and trauma.
7. Understanding parent-child interactions and healthy attachment.
8. Cultural influences in parenting and family development.
9. Building a therapeutic alliance.
10. Treatment and intervention strategies/modalities endorsed by AHCCCS.
11. Collaboration practices with other providers/caregivers.
12. A reflective practice focus.

It is the expectation of the Division that behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth through five and their families, be well trained and clinically supervised in the application of this tool. Each AdSS shall establish their own process for ensuring that all agency clinical and support services staff working with this population understand the recommended processes and procedures contained in this tool. Whenever this Practice Tool is updated or revised, each AdSS ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

J. SUPERVISION

Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R9-20-205 Clinical Supervision requirements.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development (different from administrative or clinical supervision) that focuses attention on supporting the growth of relationships that is critical to effective infant and early childhood behavioral health practice. How each of these relationships interrelates and influences the others is explored through reflective supervision and is referred to as the “parallel process.”

1. Relationship between supervisor and practitioner.
2. Relationship between practitioner, parent/caregiver/child.
3. Relationship between parent/caregiver/child.
4. Relationship between all of the above.

In each of these relationships there is an emphasis on learning, personal growth, and empathy. Through this process, supervisors assist practitioners in professional skill development and ensure that practitioners are maintaining the agency's standards for clinical performance.

Key elements of reflective supervision include reflection, collaboration, and consistency. With supervisory support, the practitioner reflects on the emotional content of the work and how one's reaction to this content affects their work. Supervisors support a practitioner's professional development through the acquisition of new knowledge by encouraging the supervisee to assess their own performance. The supervisor's ability to listen and wait allows the practitioner an opportunity to analyze their own work and its implications, and to discover solutions, concepts or perceptions on one's own, without interruption. Collaborative supervision is characterized by the development of a trusting relationship between the supervisor and practitioner in which both parties can safely communicate ideas and share responsibility for decision-making without fear of judgment. Establishment of a consistent and predictable schedule of supervisory sessions supports the professional development of infant and early childhood behavioral health practitioners.

It is the recommendation of the Division that personnel who supervise staff providing service delivery to children age birth through five and their families, receive adequate training in the elements of Reflective Practice and Supervision before implementing this approach in their supervisory activities. Criteria for provision of reflective practice is outlined on the Michigan Infant Toddler Behavioral Health website, but at minimum, Reflective Supervision requires Endorsement® for Infant Behavioral Health Specialist or Infant Behavioral Health Mentor with a minimum of 50 clock hours within a one-to-two-year timeframe. Additional information is also

available within AMPM 210 Attachment E for additional resource materials on reflective supervision and consultative practices.

Training and supervision support the acquisition of specific knowledge, skills, and competencies critical to delivering effective relationship-based services to children age birth through five and their families. While training and other academic learning venues build the practitioner's understanding of core concepts, it is through supervision that practitioners can assess their level of competency when applying these concepts within their scope of practice. When evaluating a practitioner's level of knowledge as part of supervisory activities, supervisors can compare the skills of the clinician with Endorsement® Competency Guidelines and Requirements available on either the Arizona or Michigan Infant Toddler Behavioral Health websites. However, possession of similar knowledge and skills does **not** equate to actual Endorsement®, given the proprietary nature of the Endorsement® process (e.g., evidence-based training standards, testing, ethical standards).

The Division delegates the delivery of behavioral health services to subcontracted health plans. The Division shall monitor and ensure the AdSS establish their own process for ensuring that all staff have been trained and understand how to implement the practice elements as outlined in this document. Whenever this Behavioral Health Practice Tool is updated or revised, the Division shall ensure the AdSS and their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. The Division upon request from AHCCCS, is required to provide documentation demonstrating that all required network and provider staff have been trained on this Practice Tool.

The Division shall monitor and ensure that the AdSS incorporates this behavioral health practice tool into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212 Clinical Supervision requirements.

K. ANTICIPATED OUTCOMES

1. Increased community and professional awareness of infant and early childhood behavioral health,

2. Improved use of effective screening, assessment, and service planning practices specific to the needs of children age birth through five and their families,

3. Increased knowledge and referrals to early intervention resources in the community, and

4. Improved outcomes through the use of accepted approaches in working with children age birth through five and their caregivers.

L. DIVISION OVERSIGHT OF AdSS

The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of each standard related to birth to age five, including but not limited to:

    a. Policies/procedures to ensure, and evidence of, appropriate high-need identification for the birth to five population.

    b. Policies/procedures to promote/increase availability of, and evidence of, availability of trained specialists (ITMHCA standards).

    c. Policies/procedures to ensure, and evidence of, staff training and supervision is completed as outlined in this policy.

    d. Ongoing monitoring of, and evidence of, adequate network capacity for children age birth to five.

2. Review and analyze deliverable reports submitted by the AdSS.

3. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and providing direction or support to the AdSS as necessary.

4. Ensure AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:38 PDT)
Anthony Dekker, D.O.

211 PSYCHIATRIC AND PSYCHOTHERAPEUTIC BEST PRACTICES FOR CHILDREN BIRTH THROUGH FIVE YEARS OF AGE

EFFECTIVE DATE: May 4, 2022
REFERRENCES: AMPM 211

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and the system of care for behavioral health services for members enrolled with Medicaid. This policy is an optional resource for the Tribal Health Program; it is not a requirement. The policy establishes best practice processes and goals for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions for children birth through five years of age.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the AdSS and the role of Support Coordination. While the Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this practice tool, the Division remains responsible for case management (Support Coordination) and oversight of the AdSS. Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for members. The Division shall conduct formal oversight of the AdSS. Refer to AdSS Medical Policy 211 for the roles and responsibilities of the AdSS, their subcontracted network, and providers, who furnish psychotherapeutic assessments and interventions, complete psychiatric evaluations and prescribe psychopharmacological treatment for children birth through five years of age.

B. TARGET POPULATION(S)

The target populations include all Division members eligible for ALTCS, birth through five (up to age six), receiving behavioral health services in collaboration with their caregiver(s) and Child and Family Teams (CFT). Additionally, this policy is also

applicable when working with parents and/or caregivers who have children aged birth through five, regardless of whether the child(ren) or parent were referred or are seeking services.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

Psychiatric disorders presenting in young children are a public health concern, and they can negatively impact normative developmental trajectories in all spheres, physical, social, emotional, and cognitive. One of the challenges in the field of behavioral health care for young children is the belief that young children cannot develop behavioral health disorders. Yet, these disorders if not recognized and appropriately diagnosed, may result in challenging behaviors, such as significant aggression toward others (e.g., biting, hitting, kicking) and emotional dysregulation (e.g., uncontrollable tantrums or crying). These behaviors, when not addressed, can result in serious consequences such as childcare expulsion, difficulty participating in family activities, and impaired peer relationships, making early intervention extremely important for families and caregivers that have young children with behavioral challenges.

Because of the complexities in treating infants and toddlers, the field of infant behavioral health has evolved to promote recognition of the rapid developmental processes and the importance of a healthy relationship between a secure child and the caregiver (either temporary or permanent caregiver for treatment purposes). Given the unique needs of infants and toddlers, numerous therapeutic interventions exist, summarized in a table (page 8), that can aid in reducing potentially damaging consequences. There is robust evidence supporting the use of relationship-based interventions, which focus on the child and parent/guardian/designated representative relationship. Generally, these treatment approaches focus on improving child and family/ guardian/designated representative functioning relative to the identified emotional and/or behavioral challenges and can often be successful without introduction of pharmacological intervention.

In the absence of marked or sustained improvement, it may be necessary to follow the appropriate steps toward psychotropic intervention. However, “Psychotropic

medications are only one component of a comprehensive biopsychosocial treatment plan that shall include other components in addition to medication," according to American Academy of Child and Adolescent Psychiatry.

It is critical to recognize that there are physical causes for behavioral health and developmental delays that may cause signs and symptoms which overlap with behavioral and developmental concerns. It is therefore essential to first ensure that potential physical health issues have been ruled out. Division Medical Policy 430 provides guidance for standard screening and testing for lead poisoning, which includes blood testing whenever a concern arises that indicates a need for blood lead testing.

The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. While considering whether medication should be introduced in treatment, the benefits of the medication shall be evaluated and compared to the potential biological and psychosocial side effects. According to a 2007 set of Guidelines by the Preschool Psychological Working Group, little is known about the potential effects on neurodevelopmental processes in very young children when exposed to psychotropic medications. Research summaries indicate that younger children metabolize medications differently than older children. Moreover, a review of the current literature demonstrates that there is more evidence to support psychotherapeutic rather than psychopharmacologic interventions in young children presenting with psychiatric symptoms. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications. Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.

Due to the concerns outlined above, evidence of substantial increases in prescribing antipsychotics for children and increased federal and state attention toward prescribing practices, Arizona has recognized the need to implement revised initiatives for young children to address psychotropic medication use. As of May 2016, AHCCCS provided analysis and trending of current psychotropic prescribing

practices, particularly for young children and children in the foster care system. Data analysis for this report, revealed several key findings including:

- For Arizona in general, psychotropic prescribing rates in 2013 were higher for all foster children zero to 18, when compared to non-foster care children zero to 18.
- For Arizona, foster care children zero to six were prescribed psychotropics at a rate 4.6 times higher than non-foster care children zero to six in Arizona's Medicaid system.

Based on the AHCCCS May 2016 report and the recognition that, despite continued lack of consistent national guidelines, AHCCCS has reorganized the original practice guideline into five sections, which align with current process within Arizona. Additional revisions focus on updated research and findings with regard to psychotropic prescribing practices. Focus has been added to align with current Maternal Child Health/Early and Periodic Screening Diagnostic and Treatment (MCH/EPSDT) practice, plus Bright Futures. As such, the Guidelines within this document now comprise:

- Assessment by Behavioral Health Professional/Provider
- Psychotherapeutic Interventions
- Psychiatric Evaluation
- Psychopharmacological Interventions
- EPSDT: Assessing Physical and Behavioral Needs Through Developmental Surveillance, Anticipatory Guidance, and Social/ Emotional Growth.

Refer to Division Medical Policy 210 for additional information on behavioral health screening, assessment, and treatment for children birth through five years of age.

D. ASSESSMENT BY BEHAVIORAL HEALTH PROFESSIONAL/PROVIDER

The initial assessment for a young child, at a minimum, consists of the following components as described in The American Academy for the Psychiatric Assessment of Infants and Toddlers (0-36 Months):

1. Gathering information from those individuals who are most familiar with the child, as well as direct observation of the child with their health care decision maker (HCDM) or caregiver, if directly involved with the child for treatment purposes (caregiver may be a family member or foster parent – either temporary or permanent).

2. Reason for referral including the child's social, emotional, and behavioral symptoms,

3. Detailed medical and developmental history,

4. Current medical and developmental concerns and status,

5. Family, community, childcare, and cultural contexts which may influence a child's clinical presentation,

6. Parental and environmental stressors and supports,

7. Parent/guardian/designated representative perception of the child, ability to read/ respond to child's cues, and willingness to interact with the child,

8. Children's birth through five mental status exam:

    - Appearance and general presentation
    - Reaction to changes (e.g., new people, settings, situations)
    - Emotional and behavioral regulation
    - Motor function
    - Vocalizations/speech
    - Thought content/process
    - Affect and mood
    - Ability to play by self and with peers, explore
    - Cognitive functioning
    - Relatedness to parent/guardian/designated representative

9. Use of standardized instruments to identify baseline functioning and track progress over time. Examples of such instruments include, yet are not limited to the following:

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
INFANT TODDLER SOCIAL-EMOTIONAL ASSESSMENT (BITSEA)	*Social/Emotional* Brief report questionnaire focused on child symptomatology	12 to 36 mos. Multicultural	Professional or Parents/guardians/ designated representatives
BEHAVIORAL ASSESSMENT OF BABY'S EMOTIONAL AND SOCIAL STYLE (BABES)	*Behavioral Screening for temperament*, ability to self-soothe and regulate	Ages birth to 36 months	Parent/guardian/design ated representative (for use in pediatric practices or early intervention programs)
CHILD BEHAVIOR CHECKLIST 1-5 (ASEBA) (ACHENBACH AND RESCORLA; 2001)	*Social/Emotional* Parent and teacher ratings, descriptions and concerns of child behaviors; Corresponds to DSM	Ages 1.5 years+ Multicultural	Professional Training required
PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA); (EGGER & ANGOLD, 2006)	Psychiatric diagnosis incorporating both DSM and DC:0-3R	Ages 2 to 5 years Boys/Girls Multicultural	Professional only Training required
CLINICAL PROBLEM-SOLVING PROCEDURE (CROWELL AND FLEISHMANN; 2000)	Structured observations of parent/child interactions	Ages 1 year to 5 years	Professional Videotaping essential
AGES AND STAGES QUESTIONNAIRE (ASQ-3)	Routine screening to assess developmental performance	Ages at various points from 1 month to 66 months; Boys & girls Multicultural	Parent completion
CONNOR'S EARLY CHILDHOOD ASSESSMENT	Measures specific patterns related to ADHD, cognitive and behavioral challenges	Ages 3 to 6+ Boys and Girls	Parent & teacher responses

HAWAII EARLY LEARNING PROFILE (HELP)	Assessment of developmental skills and behaviors	Ages 0 to 3 Boys & girls	Training required for use
PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)	Developmental Screening Tool – variety of domains	Birth to 8 years Boys & girls	Parent completion
TRAUMATIC SYMPTOM CHECKLIST FOR YOUNG CHILDREN (TSCYC)	Assessment of PTSD Symptoms	Normed separately for boys and girls Ages 3 to 5	Can be completed by paraprofessionals
MCHAT (2009)	A parent report screening tool to assess risk for Autism Spectrum Disorder (ASD)	Designed for use at 18 – 24 months of age	Completed by parents and scored by pediatricians, child psychiatrists or child psychologists

E. PSYCHOTHERAPEUTIC INTERVENTIONS

There is strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnoses. Thus, these specialized approaches should be the initial interventions before considering a psychopharmacologic trial (see table on following page and the Division Medical Policy 210).

The recommended psychotherapeutic treatment interventions outlined in the table below are supported by current studies and best practice. Determination of the best psychotherapeutic approach is done in conjunction with the CFT and qualified infant and early childhood behavioral health practitioners. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. Other examples of accepted therapeutic approaches with this population are referenced in Division Medical Policy 210. The psychotherapeutic intervention selected and length of treatment should be clearly documented in the clinical record.
Suggested Best Practice Interventions for Infants and Toddlers (Table not inclusive of all available therapeutic modalities – any modalities utilized will be at the discretion of the treating BHP or BHMP).

TYPE OF INTERVENTON	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
FAMILY THERAPY Training through various organizations, institutional or educational settings; Numerous master's level educational programs have dedicated programs in marriage and family therapy Marriage and Family Therapists receive specific training and clinical supervision that focuses on working with family members at the relationship level (e.g., parent- parent, parent-child or child- child)	Focus on conflict management and influence of marital conflict during high-risk perinatal period; can also be used prenatally; Goal is to ensure parent/guardian/ designated representative consensus regarding child's behavioral health status AND that parenting strategies are consistent	Infants, toddlers, preschoolers and family triad (e.g., including mother and father);	Intervention takes place at the marital relationship level, as well as the relationships between each parent and the child; focus on evaluating and changing interaction patterns between triadic members	Behavioral challenges are linked to patterns of relationship challenges; an intervention directed at one family member will always have an effect on another family member; Can change behavior by changing relationships (dyadic, triadic, family system) Theoretical assumptions, which guide family therapy intervention techniques, provide essential element of clinical framework for relationship- based work within Circle of Security, and Infant/Child Parent Psychotherapy
CHILD PARENT PSYCHOTHERAPY (CPP) Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and parent/ guardian/ designated representative	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with their high-risk parents/ guardian/ designated representative	Work at relationship level to promote partnership between child and parent/guardian/ designated representative that results in increased positive interaction and reduced discordant relationship styles	Based on premise that "nurturance, protection, culturally and age-appropriate socialization from the attachment figure(s) comprise the cornerstone of behavioral health in infancy and early childhood…"

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
INFANT PARENT PSYCHOTHERAPY Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals	Similar to Child Parent Psychotherapy, but with greater emphasis on impact of upbringing of parent/guardian/ designated representative and how that impacts current parent/guardian/ designated representative perceptions of infant and relationship with infant	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express feelings	Focus on parent/child relationship to build relationship with parent by helping caregiver understand the basis for infant behaviors and perceptions of their world (e.g., behavior based on need for safety and security)	IPP more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological challenges of parent/guardian/ designated representative as child and how those challenges impact ability to act as nurturing, protective parent/guardian/ designated representative
CIRCLE OF SECURITY Training through Circle of Security International	Therapist builds trusting relationship with parent/guardian/ designated representative (secure base) as therapist moves through relationship-based interventions to identify relational distress	Infants, toddlers & preschoolers and their parent/guardian / designated representative	Use Circle of Security interview to gain information about parent/guardian /designated representative "internal working model" regarding relationship with their child	The need for a secure attachment base is essential for building healthy relationships *Based on Attachment Theory (joint work of John Bowlby and Mary Ainswort also based on relationship-based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
APPLIED BEHAVIORAL ANALYSIS	Applied behavior analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior	Applied Behavioral Analysis Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnoses. An Early Intensive ABA (EI/ABA) program specifically for children with Autism Spectrum Disorder who begin treatment before age 4 has been described by Lovaas and others.	ABA techniques are used to decrease unwanted behaviors and increase desired behaviors through a systematic and consistent intervention. EI/ABA is provided with the goal of integrating a young child with ASD into a regular education classroom with reduced behavioral symptoms by the entry into Grade 1.	That systematic behavioral intervention can decrease unwanted behaviors and increase desired behaviors.

F. PSYCHIATRIC EVALUATION

General practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. Birth through five behavioral health significant efforts should be made to ensure that the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist with training or experience in the treatment of young children, aged 0 to 5.

The psychiatric evaluation for a young child continues to focus on gathering supplemental information that may be needed since completion of the comprehensive assessment. This is especially critical for identification of any additions or changes that may impact the child's functioning. Components may be

very similar:

1. Information from those persons who are most familiar with the child, as well as direct observation of the child with their parent/guardian/designated representative especially if changes have occurred within the caregiver constellation since the initial assessment.

2. Any potential changes in the reason for referral including changes in the child's social, emotional, and behavioral symptoms.

3. Updates related to the detailed medical and developmental history.

4. Updates related to current medical and developmental concerns and status.

5. Changes in family, community, childcare, and cultural contexts which may influence a child's clinical presentation.

6. Newly identified parental and environmental stressors and supports.

7. Ongoing or recent changes in parent/guardian/designated representative perception of the child, ability to read/respond to child's cues, and willingness to interact with the child.

8. Use of the Division Medical Policy 210 to ensure use of evidence-based Behavioral Health Practice Tool for working with infants and toddlers.

9. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved.

10. Collaboration with other agencies involved with the child and family including but not limited to Department of Child Safety (DCS), Division of Developmental Disabilities (DDD), Arizona Early Intervention Program (AzEIP), First Things First, Head Start, the local school district, Healthy

Families Arizona and other educational programs.

11. Development of DSM-5 Diagnoses and DC: 0 TO 5 Diagnosis following:

- Diagnostic Classification of Behavioral health and Developmental Disorders in Infancy and Early Childhood" (DC: 0-5).
- The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).

Current best practice for infants and toddlers, utilizes the DC: 0-5 for a number of reasons. First, it is based on Behavioral Health normed developmental trajectories, family systemic and relationship-based approaches, along with attention to individual differences in motor, cognitive, sensory, and language capabilities. Secondly, it allows for more thorough and developmentally appropriate diagnosis of behavioral health conditions in early childhood. An important feature of the DC: 0-5 is that it includes both the DSM-5 diagnostic references, as well as the corresponding ICD-10 codes. The DC: 0-5 manual was first published in 1994 as the "DC 0-3" and then revised in 2016 by Zero to Three: National Center for Infants, Toddlers, and Families (now known as "Zero to Three").

G. PSYCHOPHARMACOLOGICAL INTERVENTIONS

1. General Guidelines

If it is determined that a psychopharmacologic intervention is indicated, goals of treatment should include facilitating normative developmental processes and maximizing the potential for effective psychotherapeutic interventions. Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions, as the evidence base for the treatment of young children under the age of five is quite limited.

Clear and specific target symptoms shall be identified and documented in the clinical record prior to the initiation of a medication trial. Target symptoms and progress are continually documented in the clinical record throughout the course of treatment (Division Medical Policy 940).

Medication is always started at the lowest possible dose with subsequent increases in medication undertaken with caution. Dosing can be challenging as young children may metabolize medications more rapidly than older children. In addition, children age birth through five experience rapid growth during this timeframe, which may change the dose that is required for optimal treatment over short periods. Since these young children are often very sensitive to side effects, they shall be monitored closely.

2. Informed Consent

Informed consent, as specified in Division Medical Policy 320-Q, is an active, ongoing process that continues over the course of treatment through active dialogue between the prescribing BHMP and parent or Health Care Decision Maker about the following essential elements (Please refer to Division Medical Policy 310-V and AMPM Policy 310-V Attachment A for more information):

- The diagnosis and target symptoms for the medication recommended
- The possible benefits/intended outcome of treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- FDA status of the medication
- Level of evidence supporting the recommended medication

Although there are medications approved by the Food and Drug Administration (FDA) for young children under the age of five, an FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. In

addition, lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy. The Physician's Desk Reference states the following: "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. Thus, BHMPs shall document the rationale for medication choice and the provision of informed consent to parents/ guardians/designated representatives.

3. Monitoring

Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac and other functions or require serum level monitoring shall be assessed via appropriate laboratory studies and medical care shall be coordinated with the child's primary care physician.

4. Coordination of Care

In Arizona, the behavioral health program has historically been separated from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI). Both models have been structured in the past in such a way that eligible persons received general medical services through health plans and covered behavioral health services through a separate Contractor. Because of this separation in responsibilities, communication and coordination between behavioral health providers, AHCCCS Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of young children receiving services from both systems. Since October 1, 2019, there has been a system-wide shift toward medical health homes and provision of integrated and coordinated care, which is bringing about a shift in provider practices to address early intervention needs using a more holistic approach. Since October 1, 2019, the Division has contracted with the AdSS to implement integrated and coordinated behavioral health and physical health care.

Duplicative medication prescribing, contraindicated combinations of

prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care.

5. Polypharmacy

Polypharmacy is defined as using more than one psychotropic medication at a time with this population and is not recommended. This definition excludes a medication cross taper, where the young child may be on two medications for a short period in order to avoid abrupt withdrawal symptoms. More than one medication should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express their emotions, and developmental progress.

Complementary, alternative, and over-the-counter medications should be taken into consideration when evaluating the use of polypharmacy and potential drug interactions. If more than one medication is prescribed, there shall be documentation of clear target symptoms for each medication in the child's clinical record. When applicable, the Controlled Substance Prescription Monitoring Program (CSPMP) database should be checked (Refer to Division Medical Policy 940).

6. Medication Taper

In children who have a positive response to medication, as indicated by a remission of symptoms, a taper off medication should be considered at six to eight months of treatment. This consideration shall be clearly documented in the clinical record. The BHMP shall weigh the risks vs. benefits of each approach with the parent/guardian/designated representative, which includes the importance of reassessing the need for medication in the rapidly developing young child. Every six to eight months, a medication taper should

be considered until the child reaches the age of five. The BHMP should reassess for a persistent diagnosis and need for continuing medication at reasonable intervals beyond age five.

If the decision to taper the child off medication is made, the CFT shall be informed of this decision in order to discuss and address possible behavior disruptions that may arise as a result of this taper. The CFT shall also ensure that the need for additional supports or services for the child and/or caregiver be considered and implemented as necessary to maintain the child's stability (For specific guidelines for children involved with the Department of Child Safety and/or foster care, refer to AMPM Behavioral Health Practice Tool 260, Division Medical 320-Q, and A.R.S. § 8-514.05). Documentation of medication taper should be made with clinical rationale provided.

7. Prescription by a Non-Child Psychiatrist

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services to young children shall have training and possess experience in both psychotherapeutic and psychopharmacological interventions for children age birth through five. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible; in rural or underserved locations, this may be met through the use of telemedicine. A non-child psychiatrist BHMP shall adhere to the following when prescribing psychotropic medication for children birth through five years of age:

a. After the psychiatric evaluation has been completed and it is determined that the child may benefit from psychotropic medication(s), the case shall be reviewed with the designated child psychiatric provider as determined by the Contractor. The review shall include, at a minimum, the following elements:

   i. The proposed medication with the starting dosage,
   ii. Identified target symptoms,

iii. The clinical rationale for the proposed treatment,

iv. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/holistic providers,

v. Drug Review/Adverse Reactions,

vi. A plan for monitoring, potential side effects such as weight gain, and/or abnormal/involuntary movements, (based on recommended standards of care, and

vii. Identified targeted outcomes.

b. Follow-up consultation with a designated child psychiatric provider shall occur in the following instances:

i. If the child is not making progress towards identified treatment goals (at minimum of every three months),

ii. In the event that reconsideration of diagnosis is appropriate,

iii. When a new medication is being considered or when more than one medication is prescribed.

H. BIRTH THROUGH FIVE EPSDT: ASSESSING PHYSICAL AND BEHAVIORAL NEEDS THROUGH DEVELOPMENTAL SURVEILLANCE, ANTICIPATORY GUIDANCE AND SOCIAL/EMOTIONAL GROWTH

AHCCCS has historically incorporated the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that members under the age of 21 receive appropriate preventive and early intervention services for physical and behavioral health conditions (refer to Division Medical Policy 430). Through formal policy and reporting requirements under CMS guidelines, participation has been measured in part through use of forms designated as “EPSDT Tracking Forms” (refer to AMPM Policy 430, Attachment E).

Although AHCCCS requires use of specific EPSDT forms available on the AHCCCS website, further guidance on the use of the forms is also available through Bright

Futures. Both the Bright Futures website and Bright Futures Pocket Guide offer more detailed guidance on use of content within the tracking forms. The focus of the last section of this policy is to assist PCPs and/or pediatricians in identifying concerns related to three central EPSDT domains:

- Anticipatory Guidance,
- Developmental Surveillance, and
- Social/Emotional Growth.

Often, the primary care setting is the most robust situation available for parents to address early developmental or behavioral concerns. During the course of EPSDT-required well-child visits, physicians and pediatricians have multiple opportunities over time to build relationships with parents and their young children, while simultaneously gathering valuable information. Through discussions guided by the use of the three domains listed above, they have the chance to identify strengths, needs and stressors for the parents and children that they follow. With thoughtful use of items within these domains, it is possible for physicians to identify a physical health concern that may also involve the need for further behavioral health services. For example, a language delay or developmental regression could be due to numerous physical causes. However, both are also symptoms of early childhood trauma for children birth to three years of age. Additionally, symptoms often associated with attention deficit hyperactivity disorder (ADHD) can mirror child traumatic stress.

The challenge for physicians, due to lack of training and knowledge, is often the ability to clearly identify behavioral and developmental concerns and then link parents/guardians/ designated representatives to adequate resources. Some physicians are comfortable providing basic treatment, whereas others are not. According to one study, PCPs had various comfort levels to conduct treatment or make referrals, but it related to the diagnoses involved. There was a comfort level treating ADHD but not depression – the preference for the latter, in most instances was to make a behavioral health referral.

Given acknowledgement to the lack of behavioral health training within the pediatric

community, dedicated and thorough use of EPSDT forms, as well as guidance provided under Bright Futures, can aid physicians in providing appropriate and early intervention treatment for children birth through five. The center sections of EPSDT forms offer opportunity to work with parents/guardians/designated representatives to offer guidance and encourage referrals to and use of behavioral health system when there is concern about behaviors that may indicate a potential behavioral health condition.

Although it is not the purpose of this policy to offer extensive details regarding early childhood developmental and behavioral health issues, the table below provides some examples of how EPSDT Developmental Screening sections can prompt opportunities (based on specific age-appropriate EPSDT domains) for discussion between parents/Responsible Person and PCPs regarding observations and concerns identified during visits. PCPs have multiple options at these visits to suggest community supports, case manager involvement (if available under the Medical Health Home model) or refer to behavioral health system/provider for further assistance (Refer to Division Medical Policy 580 for information on the Behavioral Health Referral Process).

The table below is designed to present bivariate ways (e.g., physical or behavioral) to examine developmental milestones, environmental factors and level of social/emotional growth. Because physical and familial environments have such a tremendous impact on the developing brain, it is important to recognize that if infants and toddlers are not meeting milestones, there could be either physical, environmental or behavioral health reasons.

EPSDT Domain Sample Table: Potential indicators for referral to Behavioral Health Services (Based on age, domain & need). (AMPM Policy 430, Attachment E; Bright Futures, 4th Edition)

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	6 months	Sits without support, babbles sound such as "ma", "ba", "ga", looks when name is called.	Parent/guardian/designated representative engages with and is attentive toward infant; if infant is engaging in these early milestone behaviors, and there is lack of reaction or acknowledgement from parent, or reciprocal engagement explore further for evidence of potential maternal depression or other environmental factors (unsafe environment, violence, neglect) that may be causing stress or trauma for the infant.
ANTICIPATORY GUIDANCE PROVIDED	6 months	Discussion of social determinants of health (e.g., safe sleep, sleep/wake cycles, tobacco use, safe environment).	Any potential risk factors identified under this domain may warrant referral for community supports or referral for behavioral health services if there is concern about parental depression, substance use, neglect of child or dangerous environment).
SOCIAL EMOTIONAL HEALTH	6 months	Appropriate bonding and responsive to needs.	Is parent/guardian/designated representative feeding infant and engaging while feeding or is infant being fed via bottle propping while in carrier or crib? Lack of infant/parent engagement may warrant further discussion and referral to behavioral health system due to potential indicators for maternal depression or lack of appropriate bonding/attachment. Lack of appropriate bonding can manifest in multiple ways (lack of eye contact between baby and caregiver, baby shows signs of discomfort when being held, inability for caregiver to help baby sooth).
ANTICIPATORY GUIDANCE PROVIDED	1 yr.	Continued focus on social determinants of health such as food security, safe environment, parental use of tobacco, alcohol or other substances.	If there are parental risk factors for social determinants of health, there are opportunities to refer for community supports or behavioral health; in case there are underlying behavioral health needs (e.g., parental depression, substance use).
SOCIAL EMOTIONAL HEALTH	1 yr.	Prefers primary caregiver over others, shy with others, tantrums.	Lack of preference for primary caregiver could indicate insecure attachment for variety of reasons (e.g., lack of trust, abuse, neglect, early trauma); consider unaddressed behavioral health issues in parent.

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	3 yrs.	Eats independently, uses three word sentences, plays cooperatively and shares.	Lack of these observed developmental milestones may be indicative of physical issues or lack of parental engagement with child; consider referral for community supports and/or behavioral health system to address potential for undiagnosed behavioral health issue on the part of the parent or child (barring any evidence of physical reasons).
ANTICIPATORY GUIDANCE PROVIDED	3 yrs.	Allow child to play independently; be available if child seeks out parent or caregiver.	Attachment issues can manifest as fear in child to play independently, even if allowed (over-dependence on caregiver), or reluctance of child to seek out parent/guardian/designated representative due to lack of secure "attachment" base. Could also be signs/symptoms related to abuse.
SOCIAL EMOTIONAL HEALTH	3 yrs.	Separates easily from parent, shows interest in other children, kindness to animals.	Observe parental conversations and interaction; is parent positive with child, offering praise, setting appropriate boundaries; lack of these observed behaviors on the part of either parent or child may indicate unaddressed child/parent relationship issues or potential mental issue issues for either parent or child.

I. DIVISION OVERSIGHT OF AdSS

The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of standards related to birth to age five.

2. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and providing direction or support to the AdSS as necessary.

3. Ensure AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:35 PDT)

Anthony Dekker, D.O.

230 SUPPORT AND REHABILITATION SERVICES FOR CHILDREN, ADOLESCENTS AND YOUNG ADULTS

EFFECTIVE DATE: June 15, 2022

REFERENCES: A.A.C. R9-10-115, AMPM Chapter 200, Division Medical Policy 320-O

PURPOSE

This policy applies to the AHCCCS System of Care for ALTCS eligible members. The policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the Administrative Services Subcontractors (AdSS) and the role of Support Coordination. The policy establishes the expectations for the implementation of support and rehabilitation services as they are used in CFT practice. This policy does not apply to the Division's Tribal Health Program but may be used as an optional resource.

DEFINITIONS

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or health care decision maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the

needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Support and Rehabilitation Service Providers provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration, or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

BACKGROUND

In March of 2007, ADHS/DBHS launched the Meet Me Where I Am (MMWIA) campaign with the intention of increasing the availability of Support and Rehabilitation Services. As a result of administrative simplification this goal remains a priority of AHCCCS. As part of the MMWIA campaign, nine modules were created and placed online offering assistance to practitioners of direct support services. These modules can be accessed at mmwia.com and referenced in this document.

POLICY

Support and rehabilitation services are an essential part of community-based practice and culturally competent care. These services help children live

successfully with their families in the community. Adhering to the expectations of this policy will enhance behavioral health outcomes for children and young adults. The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy, and whose contract includes this requirement. The Division remains responsible for support coordination and oversight of the AdSS. Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for their members and participants of Child and Family Team (CFT) meetings. The Division shall conduct formal oversight of the AdSS. Refer to AdSS Medical Policy 230 for responsibilities of the AdSS implementing this policy.

A. SERVICE DEVELOPMENT

1. The Division performs oversight of the AdSS to ensure the following occurs in relation to service development:

    a. CFTs have access to the full range of Support and Rehabilitation Services;

    b. CFT facilitators and families are aware of the value of Support and Rehabilitation Services, as well as specific and current information regarding the different provider options available in their area;

    c. The AdSS adopt a Support and Rehabilitation Services system model outlining how these services will be structured in their region and their relation to other behavioral health services and providers. (Refer to Module 9, System and Program Models for Support and Rehabilitation Services Provision, of the online MMWIA modules for more information.)

d. Support and Rehabilitation Services are available to meet the behavioral health needs of youth and families as identified in their CFTs.

2. Division Support Coordinators shall participate in member CFT meetings to ensure integrated care coordination.

B. INTEGRATING SUPPORT AND REHABILITATION SERVICES WITH CFT PRACTICE

The CFT shall complete the following tasks when planning and arranging for Support and Rehabilitation Services. (Refer to Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, of the online MMWIA modules for detailed information about each task.)

1. Assess the underlying needs of the child/family and consider the various options presented through Support and Rehabilitation Services for meeting those needs. These options may include family, natural and community resources, resources of other involved stakeholder agencies (such as DCS, DDD, and family-run support or advocacy organizations) as well as paid behavioral health resources. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan. (Refer to Division Medical

Policy 320-O.)

2. Locate and select Support and Rehabilitation Services provider(s) to help implement the plan. Collaborate with and use information provided by the Contractors to do the following:

   a. Determine which Support and Rehabilitation Services providers may meet the needs identified, determine whether those providers have current capacity, and

   b. Make a referral to the selected provider(s).

3. Work with the Support and Rehabilitation Services provider(s) to define their roles and tasks, specifying the anticipated frequency and duration associated with the Support and Rehabilitation Services requested. The CFT ensures this information is recorded in the service plan and the Support and Rehabilitation Services provider(s) promptly receive a copy of the plan. If unplanned services are needed due to crisis situations, the CFT notes this change in the service plan and the Support and Rehabilitation Services provider is authorized to respond with additional support if needed.

4. Coordinate effectively with the Support and Rehabilitation Services providers on an ongoing basis. This may be accomplished through CFT meetings as well as through regular communication with the Support and Rehabilitation Services provider. The CFT Facilitator/case manager sends the Support and Rehabilitation Services provider a complete Referral Packet

which includes copies of any updated assessments, service plans, notice of change to funding status, and other important documents whenever updates occur.

5. Support and Rehabilitation Services shall be documented accurately and differentiate between which services were provided. Module 1, Overview of Support and Rehabilitation Service Provision, of the MMWIA modules provides several appendices intended to assist with code differentiation and billing limitations of Support and Rehabilitation Services.

6. Monitor progress and adjust the Support and Rehabilitation Services provision as necessary. The CFT, which includes the Support and Rehabilitation Services provider, makes necessary adjustments to the authorized Support and Rehabilitation Services. These include the type, anticipated frequency and duration of the service(s), as well as and documents any changes in the service plan. CFTs meet regularly and make needed adjustments in the implementation of Support and Rehabilitation Services, both when services are successful and when they need to be modified because they are not achieving desired results.

7. All support and Rehabilitation Services should be provided using a Positive Behavior Support (PBS) philosophy. Module 3, Using Positive Behavior Support to Provide Effective Support and Rehabilitation Services, of the online MMWIA modules contains information regarding this type of approach. PBS is intended as

a meta-theory to guide Support and Rehabilitation Services provision rather than as a specific type of program. It is not the intent of the Division to prescribe specific programming practices, but rather to endorse the principles underlying Positive Behavior Support, such as focus on strengths, enhancing quality of life and eliminating coercive or punitive approaches.

8. When clinically appropriate, the CFT will direct a plan to discontinue formal Support and Rehabilitation Services delivery ensuring that the youth and family have been connected to community resources or services and natural support services that will provide ongoing support. (Refer to MMWIA Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, for more information about when it may be appropriate to end Support and Rehabilitation Services as well as suggestions for transition from these services.)

C. RESPONSIBILITIES REGARDING SUPPORT AND REHABILITATION SERVICES PROCESSES

1. AdSS and their network of behavioral health providers shall maintain and make available to the CFT, current and accurate information regarding Support and Rehabilitation Services providers and their current capacity/availability to provide support.

2. AdSS and their network of behavioral health providers shall require that Support and Rehabilitation Services providers use a standardized referral process that helps providers receive, store,

track, and respond in writing to all referrals received from CFT facilitators/case managers.

3. To better assess the need for increased Support and Rehabilitation Services capacity, AdSS and their network of behavioral health providers shall monitor information from CFT Facilitators/case managers who are unable to locate Support and Rehabilitation Services requested by the CFT in a timely manner. Information gathered may include the date of the request(s), number of providers approached, the type and/or amount of Support and Rehabilitation Services sought by the team, and what the team did as an alternative to address the needs of the youth and family.

4. AdSS and their network of behavioral health providers shall create and oversee a process whereby Support and Rehabilitation Services providers receive copies of any and all of the following documents in a timely manner each time they are updated. These documents are needed for quality service provision, and may also be necessary in the event of data validation audits they include:

   a. Assessments and Addenda,

   b. Review of Progress forms,

   c. Service Plan Documents,

   d. Data demographic forms,

e. Crisis/Safety Plans,

f. Strengths, Needs and Culture Discoveries, and

g. Child and Family Team Notes (if separate from the above items).

5. AdSS and their network of behavioral health providers shall ensure that procedures are in place to require Support and Rehabilitation Services providers to do the following:

a. Respond to referrals in a timely manner, (Refer to AdSS Operations Policy 417),

b. Participate actively in Child and Family Teams

c. Provide information regarding service delivery as it relates to established child/family goals, and

d. Provide training and supervision necessary to help staff provide effective Support and Rehabilitation Service as outlined by the CFT.

6. AdSS and their network of behavioral health providers shall develop a process to ensure that when children and families are receiving intense Support and Rehabilitation Services or are receiving them for an extended period of time, services are reviewed periodically to ensure resources are being used effectively. Such review should be done in person with the CFT rather than outside of the team. During such reviews, case-specific factors identified by the CFT as being important to the success of the family must be considered.

7. AdSS and their network of behavioral health providers shall develop processes to track outcomes of Support and Rehabilitation Services both qualitatively (such as narrative success stories) and quantitatively (such as outcome data).

D. TRAINING AND SUPERVISION RECOMMENDATIONS

1. AdSS and their network of behavioral health providers shall establish processes for ensuring all clinical and support services staff working with children and adolescents understand the elements for development and use of Support and Rehabilitation Services as specified in this document through formal training as noted here, including required reading of this Policy.

2. Several training resources have been developed as part of the MMWIA campaign to assist families, providers, and community members in using Support Rehabilitation Services effectively. Specifically, nine self-guided training modules/toolkits are available for any individuals or agencies across the state that participates in CFTs. These modules may be accessed online at www.mmwia.com.

3. AdSS and their network of behavioral health providers shall provide documentation, upon request from the Division or AHCCCS, demonstrating that all required network and provider staff have been trained on the elements contained in this policy. Whenever this policy or the attendant training modules are updated or revised, AdSS shall ensure their subcontracted network and provider agencies are notified and required staff are

retrained as necessary on the changes.

4. Supervision regarding implementation of this policy is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in accordance with A.A.C. R9-10-115, Behavioral Health Paraprofessionals, Behavioral Health Technicians.

E. AdSS OVERSIGHT

1. The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this policy and policies referenced within this policy:

   a. Annual Operational Review of compliance with this policy and related standards, including but not limited to:

      i. Policies/procedures for, and evidence of, assessing and prioritizing identified need for MMWIA services.

      ii. Policies/procedures for, and evidence of, tracking and documenting demand/unmet need for MMWI services.

      iii. Policies/procedures, and evidence of, implementing strategy for addressing the lack of timely availability of MMWIA services.

      iv. Policies/procedure for, and evidence of, managing and documenting service utilization/length of stay for MMWIA services.

      v. Evidence of training as described in section Training and Supervision above.

b. Receive and analyze deliverable reports or other data as submitted by the AdSS.

c. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

d. Ensure AdSS complete ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:33 PDT)

Anthony Dekker, D.O.

280 TRANSITION TO ADULTHOOD

EFFECTIVE DATE: June 29, 2022

REFERENCES: A.A.C. R4-6-212, IDEA Part B, Section 1415 (m), Section 504 of the Rehabilitation Act of 1973

PURPOSE

This policy applies to the AHCCCS System of Care for ALTCS eligible members. This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the Administrative Services Subcontractors (AdSS) and the role of support coordination. This policy is an optional resource for the Tribal Health Program and is not a requirement for the Tribal Health Program.

The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy. The Division remains responsible for support coordination and oversight of the AdSS.

The purpose of this policy is to strengthen practice in the system of care and promote continuity of care through collaborative planning by:

1. Supporting individuals transitioning into early adulthood in ways that reinforce their recovery process.
2. Ensuring a smooth and seamless transition from the AHCCCS Children System of Care to the AHCCCS Adult System of Care.
3. Fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of 18.

DEFINITIONS

Adult Recovery Team (ART) is a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member, member's health care decision maker (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

Assessment – Behavioral Health means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) is a group of individuals that includes, at a minimum, the child and their family, or health care decision maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division. The size, scope, and

intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Serious Mental Illness is a designation as specified in A.R.S. 36-550 and determined in an individual 18 years of age or older.

Serious Mental Illness Evaluation is the process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a determination as to an individual's serious mental illness eligibility.

BACKGROUND

The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated: "Traditionally, early adulthood has been a period when young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult

period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development." While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.

Between 2008 and 2017, the amount of adults that experienced serious psychological distress in the last month increased among most age groups, with the largest increases seen among younger adults aged 18-25 (71%). Notably, rates of serious psychological distress increased by 78% among adults aged 20-21 during the time period. Meanwhile, there was a decline among adults aged 65 and older.

These findings were consistent across other measures, with the rate of adolescents and young adults experiencing depressive symptoms in the last year increasing by 52% and 63%, respectively, while rates remained stable adults aged 26 and older.

As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially getting married and becoming parents. While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more "intangible, gradual, psychological, and individualistic terms." Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting "responsibility for the consequences of your actions," deciding one's "own beliefs and values independently of parents or other influences," and establishing "a relationship with parents as an equal

adult."

Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.

With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20's may still require the support of their families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities. For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.

Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a serious mental illness. Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.

POLICY

This policy addresses the recommended practice for transitioning youth from the AHCCCS Children System of Care to the AHCCCS Adult System of Care, with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood, and as specified in AMPM 520 which requires that transition planning begins when the youth reaches the age of 16, however, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age 16 and older at the time they enter the AHCCCS System of Care, planning shall begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the AHCCCS Adult System of Care, but also as a transition to adulthood.

Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for their members. The Division shall provide formal oversight of the AdSS to ensure compliance with AdSS Medical Policy 280.

A. SERIOUS MENTAL ILLNESS DETERMINATIONS

1. When the adolescent reaches the age of 17 and the CFT believes that the youth may meet eligibility criteria as an adult designated as having a Serious Mental Illness (SMI), the Division and subcontracted providers shall ensure the young adult receives an eligibility determination at the age of 17.5, as specified in Division Medical Policy 320-P.

2. If the youth is determined eligible, or likely to be determined eligible for services as a person with a SMI, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services case manager to upcoming planning meetings. When more than one behavioral health service provider is involved, the responsibility for collaboration lies with the provider who is directly responsible for behavioral health service planning and delivery.

3. If the young adult is not eligible for services as a person with a SMI, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

B. REQUIREMENTS FOR INFORMATION SHARING PRACTICES, ELIGIBLE SERVICE FUNDING, AND DATA SUBMISSION UPDATES

1. Prior to releasing treatment information, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per AMPM 940.

2. If the young adult is not Medicaid eligible, services that can be provided under non-Medicaid funding will follow policy guidelines as specified in AMPM Policy 320-T1.

3. The behavioral health provider will ensure that the behavioral health category assignment is updated along with other demographic data consistent with the AHCCCS Technical Interface Guidelines.

4. Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning. A full assessment is not required at the time of transition from child to adult behavioral health services unless an annual update is due or there have been significant changes to the young adult's status that clinically indicate the need to update the Assessment or behavioral health Service Plan.

C. KEY PERSONS FOR COLLABORATION

1. Team Coordination:

   When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. This coordination must be in place no

later than four-six months prior to the youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.

Orientation of the youth, their family and CFT to potential changes they may experience as part of this transition to the AHCCCS Adult System of Care will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an ambassador for the incoming young adult and their involved family and/or caregiver.

As noted in AMPM 220, the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain their current CFT until the youth turns 21. Regardless of when the youth completes their transition into the AHCCCS Adult System of Care, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Collaboration between the child and adult service provider for transition age youth is more

easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.

2. Family involvement and culture must be considered at all times especially as the youth prepares for adulthood. Although this period in a young person's life is considered a time for establishing their independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.

   During this transitional period, the role that families assume upon their child turning 18 will vary based on:

   a. Individual cultural influences,

   b. The young adult's ability to assume the responsibilities of adulthood,

   c. The young adult's preferences for continued family involvement, and

   d. The needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.

3. Understanding each family's culture can assist teams in promoting successful transition by:

   a. Informing families of appropriate family support programs available in the AHCCCS Adult System of Care,

   b. Identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the AHCCCS Adult System of Care,

   c. Recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence, and

   d. Addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.

   Some youth involved with DCS may express a desire to reunite with their family from whose care they were removed. In these situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.

D. SYSTEM PARTNERS

Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18. Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 21. Youth in foster care may be eligible for services through a

program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP) through the Arizona Department of Child Safety (DCS).

System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:

1. Birth certificates.
2. Social security cards and social security disability benefit applications.
3. Medical records including any eligibility determinations and assessments.
4. Individualized Education Program (IEP) Plans.
5. Certificates of achievement, diplomas, General Education Development transcripts, and application forms for college.
6. Case plans for youth continuing in the foster care system,
7. Treatment plans.
8. Documentation of completion of probation or parole conditions.
9. Guardianship applications.
10. Advance directives.

E. NATURAL SUPPORT

Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social

relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:

1. Identify what supports will be needed by the young adult to promote social interaction and relationships.
2. Explore venues for socializing opportunities in the community.
3. Determine what is needed to plan time for recreational activities.
4. Identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.

F. PERSONAL CHOICE

Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf. This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:

1. Arizona Vision and 12 Principles for Children's Service Delivery, and
2. Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.

G. CLINICAL AND SERVICE PLANNING CONSIDERATIONS

The Division supports clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the AHCCCS Adult System of Care. This partnership is built through respect and equality, and is based on the expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.

H. CRISIS AND SAFETY PLANNING

The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as specified in AMPM 220. For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the AHCCCS Adult System of Care and how to access them in their time of need.

I. TRANSITION PLANNING

The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.

1. Self-care and Independent Living Skills

   As the youth approaches adulthood, the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills, how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.

2. Social and Relational Skills

The young adult's successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.

3. Vocational/Employment

An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of

meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.

Service planning that addresses the youth's preparation for employment or other meaningful activity can include:

a. Utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities,

b. Identifying skill deficits and effective strategies to address these deficits,

c. Determining training needs and providing opportunities for learning through practice in real world settings,

d. Learning about school-to-work programs that may be available in the community and eligibility requirements,

e. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, etc. and

f. Learning federal and state requirements for filing annual

income tax returns.

Youth involved in school-based work activities (paid or non-paid) are able to “test the waters'' of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth’s freshman year of high school. When youth reach the age of 14 they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work-related opportunities will assist teams in determining where the youth excels or struggles in each type of work undertaken, the types of supports that might be needed, and what the best “job match” might be in terms of the youth’s personal interests and skill level.

As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth’s chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment. Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as

well as employer related accommodations may be necessary to ensure that the young adult can continue to perform their job duties.

4. Vocational/Employment Considerations for Youth with Disabilities

For youth who have a disability, regardless of whether they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) under a Vocational Rehabilitation (VR) program when transitioning from school to work. The school can refer youth with a disability to the VR program as early as age 14 or at any time thereafter when they are ready to work with VR to address their career plans. Students with disabilities between the ages of 14 and 22 are able to participate in Pre-Employment Transition Services as potentially eligible students, meaning they do not have to be VR clients. Pre-Employment Transition Services are group based, general workshops covering five topic areas that may provide the information a youth needs to begin the career exploration process, develop skills for successful employment and learn about post-secondary education opportunities. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment. Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for DES/RSA program services. Refer to DES/RSA for information on the VR process regarding intake/eligibility, planning for employment, services, and program limitations.

5. Education

Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. Asking the youth to share their individualized plans with the rest of the team may provide information to assist with transition planning. Individualized plans could include:

a. Education Career Action Plan (ECAP),

b. 504 Plan,

c. Transition Plan, and

d. Summary of Performance.

6. Individualized Plans

a. Educational Consideration for all Students:

i. Education Career Action Plan - In 2008 the Arizona State Board of Education approved Education and Career Action Plans for all Arizona students in grades 9-12. The ECAP is intended to develop the young adult's individual academic and career goals. An ECAP process portfolio has attributes that should be documented, reviewed, and updated, at a minimum, annually; academic, career, postsecondary, and extracurricular.

b. Education Considerations for Youth with Disabilities:

i. 504 Plan — Section 504 of the Rehabilitation Act of 1973 protects the civil rights of individuals with disabilities in programs and activities that receive federal funds. Recipients of these funds include public school districts, institutions of higher education, and other state and local education agencies. This regulation requires a school district to provide accommodations that can be made by the classroom teacher(s) and other school staff to help students better access the general education curriculum through a 504 Plan that outlines the individualized services and accommodations needed by the student.

ii. Transition Plan - While youth are in secondary education, Individuals with Disabilities Educational Act (IDEA) requires public schools to develop an individualized transition plan for each student with an IEP. The transition plan is the section of the IEP that is put in place no later than the student's 16th birthday. The purpose of the plan is to develop postsecondary goals and provide opportunities that will reasonably enable the student to meet those goals for transitioning to adult life. All of the following components are required as part of the transition plan:

1) Student invitation to all IEP meetings where transition topics are discussed.

2) Age-appropriate transition assessments.

3) Measurable Postsecondary Goals (MPGs) in the areas of:

   a) Education/Training,

   b) Employment, and

   c) Independent living, (if needed).

4) Annually updated MPGs.

5) Instruction and services that align with the student's MPGs:

   a) Coordinated set of transition activities,

   b) Courses of study, and

   c) Annual goals.

6) Outside agency participation with prior consent from the family or student that has reached the age of majority.

   a) Summary of Performance (SOP). The SOP is required under the reauthorization of the IDEA Act of 2004. An SOP is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE under State law. In Arizona, the student reaches the maximum age of eligibility upon

completing the school year in which the student turns 22. A Public Education Agency must provide the youth with a summary of their academic achievement, functional performance, and recommendations on how to assist in meeting the young adult's postsecondary goals. The SOP must be completed during the final year of a student's high school education.

7. Other Considerations

   a. Transfer of Rights' Requirement for Public Education Agencies. Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

      i. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18, and

      ii. In order to prepare youth with disabilities for their transfer of rights, it is necessary for

parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health provider, should assist the youth/parent/caregiver with this process.

b. A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.

8. Postsecondary Education Considerations

When postsecondary education is the goal for young adults, transition planning may include preparatory work in a number of areas, including, but not limited to, matching the young adult's interests with the right school, connecting the youth to the preferred schools Disability Resource Center if accommodations are needed, assisting with applications for scholarships or other financial aids, etc. The CFT should anticipate and help plan for such needs. If accommodations are needed, connect the youth with the Disability Resource Centers from their preferred postsecondary institutions, and

9. Medical/Physical Healthcare

Planning can include assisting the youth with:

a. Transferring healthcare services from a pediatrician to an adult health care provider, if pertinent,

b. Applying for medical and behavioral health care coverage, including how to select a health plan and a physician,

c. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services,

d. Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures),

e. Information on advance directives as indicated in the Division Medical Policy 640,

f. Methods for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication,

g. How to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis, and

h. Assuming responsibility for understanding and managing the symptoms of their mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

10. Living Arrangements

Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home

with family, with a relative, in a behavioral health inpatient or residential facility, other out-of-home treatment setting), or whether they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently, identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting their needs and addresses any personal safety concerns.

The most common types of living situations range from living independently in one's own apartment, with or without roommates, to a supported or supervised type of living arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to Arizona 2-1-1 for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs**.**

Youth living in a behavioral health inpatient facility at the time they turn age 18 can continue to receive residential services until the age of 22 if they were admitted to the facility before their 21st birthday and continue to require treatment.

Licensed residential agencies may continue to provide behavioral health services to individuals aged 18 or older if the following

conditions are met as specified in A.A.C. R9-10-318 (B):

a. Person was admitted before their 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job training program, is not 21 years of age or older, or

b. Through the last day of the month of the person's 18th birthday.

11. Financial

Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security Disability programs, food stamps, or other emergency assistance will cover the young adult's financial responsibilities. Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.

Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for Social Security Income (SSI) benefits as a child will have a disability redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits. The team can assist the young adult and their

family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.

Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:

a. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions,

b. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area,

c. Learning how to monitor spending and budget financial resources,

d. Education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments, and

e. Understanding the short and long-term consequences of poor financial planning (e.g., overdrawn account [Non-Sufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss).

12. Legal Considerations

Transition planning that addresses legal considerations ideally begins when the youth is 17.5 years of age to ensure the young adult has the necessary legal protections upon reaching the age

of majority. This can include the following:

a. Document Preparation

Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may choose to draw up a Will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:

i. Guardianship,

ii. Conservator,

iii. Special needs trust, and

iv. Advance directives (e.g., living will, powers of attorney).

b. Legal Considerations for Youth with Disabilities

Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of their life. Refer to the Arizona Center for Disability Law's Legal Options Manual for access to information and forms. This publication also addresses tribal jurisdiction in relation to

the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

13. Transportation

A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.

When transitioning to the adult behavioral health system, educate the family and young adult on the transportation options available through the adult service delivery system. This will help support the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with identifying and planning for other transportation needs that are not necessarily associated with accessing medical or behavioral

health services.

14. Personal Identification

The team can assist the youth with acquiring a State issued identification card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division. An identification card is available to all ages (including infants); however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.

15. Mandatory and Voluntary Registrations

Selective Service registration is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security Number is not needed. When a Social Security Number is obtained after registration is completed, it is the responsibility of the young adult male to inform the Selective Service System.

Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.

J. TRAINING AND SUPERVISION RECOMMENDATIONS

1. The practice elements of this policy apply to Division, AdSS, and subcontracted network and provider behavioral health staff who participate in assessment and service planning processes, provider case management and other clinical services, or who

supervise staff that provide service delivery to adolescents, young adults, and their families.

2. The Division shall monitor the AdSS to ensure each AdSS has established a process for ensuring the following:

   a. Staff are trained and understand how to implement the practice elements outlined in this policy;

   b. The AdSS' network and provider agencies are notified of changes in policy and additional training is available if required; and

   c. Upon request from AHCCCS or the Division, the AdSS shall provide documentation demonstrating that all required network and provider staff have been trained on this policy.

3. The Division shall monitor the AdSS for incorporation of this policy into other supervision processes the AdSS and their network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212, Clinical Supervision Requirements.

K. AdSS OVERSIGHT

The Division shall use, at a minimum, the following methods to ensure the AdSS are in compliance with AdSS Medical Policy 280 and associated policies:

1. Annual Operational Review of compliance with standards for Transition Aged Youth (TAY) and related evidence-based programs, including but not limited to:

a. Policies/procedures to promote, and evidence of, adequate programming for TAY utilizing the Transition to Independence (TIP) Model, or other evidence-based programs for this population.

b. Policies/procedures to track numbers, and evidence of, staff currently trained in TIP evidence-based programs.

c. Policies/procedures to analyze, and evidence of, sufficiency of current First Episode Psychosis (FEP) programming for TAY (aged 18-24).

d. Evidence of the AdSS completing an analysis of the data in Sections J.(1)(a.)(b.)(c.) and any related plans for developing additional FEP programming for TAY.

2. Analyze deliverable reports or other data as required, including but not limited to, Provider Network Development and Management Plans demonstrating network adequacy and plans to promote specialty services described in this policy.

3. Conduct oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.

4. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 24, 2022 10:14 PDT)
Anthony Dekker, D.O.

300 CHAPTER OVERVIEW

REVISION DATE: 10/1/2021, 5/24/2021, 5/13/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

The services described in this Chapter are available to members enrolled in Title XIX. This includes Targeted (Title XIX Acute) and Arizona Long Term Care Services (ALTCS) members.

Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in American Indian Health Plan.

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers, and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member's designated physician who coordinates all aspects of the member's medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System (ALTCS).

If the member who is long term care eligible is enrolled in a health plan and has a PCP, but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services

Members eligible for ALTCS may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.

Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days.

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

Comprehensive Health Plan

The Comprehensive Health Plan (CHP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CHP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division's contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. All services must be provided or approved by the primary care provider

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

A. Prior authorization of services and procedures as specified by the health plan.

B. Claims processing according to policies and procedures defined by the health plan.

C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.

D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.

E. Provider relations and member services activities.

F. Financial monitoring and reporting as mandated under AHCCCS rules.

G. All other quality assurance and utilization management activities as defined in the Title 42 of the Code of Federal Regulations (http://www.gpoaccess.gov/cfr/), AHCCCS Rules (azahcccs.gov/Regulations/), and the health plan's quality assurance/utilization review procedures.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/Arizona).

310-A AUDIOLOGY

EFFECTIVE DATE: March 3, 2017

REFERENCES: 42 CFR 440.110

The Division of Developmental Disabilities (Division) covers medically necessary audiology services to evaluate hearing loss for all members, on an inpatient and outpatient basis. Only an AHCCCS-registered dispensing audiologist or an AHCCCS-registered individual with a valid hearing aid dispensing license may dispense hearing aids. Hearing aids, provided as a part of audiology services, are covered only for members for members age 21 and under who are eligible for AHCCCS.

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR 440.110). Out-of-state audiologists must meet the federal requirements.

The federal requirements mandate that the audiologist have a master's or doctoral degree in audiology and meet one of the following conditions:

A. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

B. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified master's or doctoral-level audiologist), performed at least nine months of supervised full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

310-B TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES

REVISION DATE: 8/2/2023, 3/17/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-210.01; CFR 493, Subpart A; CFR Title 42, Chapter IV, Subchapter G, Part 482; 42 CFR 440.10; 42 CFR 441; 42 CFR 483; A.R.S. Title 32, Chapter 33; A.R.S. Title 36, Chapter 4; A.R.S. §32-3251; A.R.S. §36-501; A.R.S. §32-2061; A.R.S. §32-2091; A.A.C. 14-101; A.A.C. R4-6-101; A.A.C. R9-10-200; A.A.C. Title 9, Chapter 10 (9 A.A.C. 10); A.A.C. R9-10-1016; A.A.C. R9-10-1012; A.A.C. R9-21-20; A.A.C. R9-10-316; A.A.C. R9-10-318; A.A.C. R9-10-316; A.A.C. R9-10-1025; A.A.C. R9-10- 1600; A.A.C. R9-10-1000; A.A.C. R9-10-300; AMPM Chapter 100; AMPM 109; AMPM Exhibit 310-1; AMPM 310-B; AMPM 310-BB; AMPM 310-V; AMPM 320-0; AMPM 320-S; AMPM 320-V; AMPM 320-W; AMPM 320-X; AMPM 570; AMPM 590; AMPM 963; AMPM 964; AMPM 965; ACOM Policy 447; ACOM Policy 436

PURPOSE

This policy describes the Division of Developmental Disabilities (Division) responsibilities for providing Title XIX/XXI Behavioral Health Services to Members who are eligible for Arizona Long Term Care System (ALTCS), including additional requirements for Members that have chosen the DDD Tribal Health Program (THP) as their health plan.

DEFINITIONS

1. “Bed Hold” means days in which the facility reserves the Member’s bed, or Member’s space in which they have been

residing, while the member is on an authorized/planned overnight leave from the facility for the purposes of therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning as specified the Arizona State Plan under Title XIX of the Social Security Act.

2. "Behavioral Health Paraprofessional" or "BHPP" means an individual who is not a Behavioral Health Professional who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:

   b. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and

   c. Are provided under supervision by a Behavioral Health Professional.

3. "Behavioral Health Professional" or "BHP" means

   b. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,

c. A psychiatrist as defined in A.R.S. §36-501,

d. A psychologist as defined in A.R.S. §32-2061,

e. A physician,

f. A behavior analyst as defined in A.R.S. §32-2091,

g. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

h. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing Behavioral Health Services

4. “Behavioral Health Services” means physician or practitioner services, nursing services, health-related services, or ancillary

services provided to an individual to address the individual's behavioral health needs.

5. "Behavioral Health Technician" or "BHT" means an individual who is not a BHP who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:

   b. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, would be required to be licensed as a Behavioral Health Professional under A.R.S. Title 32, Chapter 33, and

   c. Are provided with Clinical Oversight by a BHP.

6. "Clinical Oversight" means monitoring the Behavioral Health Services provided by a Behavioral Health Technician to ensure that the Behavioral Health Technician is providing the Behavioral Health Services according to the Health Care Institution's policies and procedures by:

   a. Providing on-going review of a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services,

b. Providing guidance to improve a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services, and

c. Recommending training for a Behavioral Health Technician to improve the Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services.

7. "Clinical Team" means Child and Family Teams and Adult Recovery Teams.

8. "Community Service Agencies" or "CSAs" means an unlicensed provider of non-medical, health related, support services. CSAs provide:

a. Individualized habilitation

b. Developmental learning,

c. Rehabilitation

d. Relearning or readapting,

e. Employment,

f. Advocacy services,

g. Peer support, and

h. Family support.

6. “Family Support Services” means home care training or family support with family member(s) directed toward restoration, enhancement, or maintenance of the family functions in order to increase the family’s ability to effectively interact and care for the individual in the home and community.

7. “Health Care Institution” means every place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, Behavioral Health Services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies, outdoor behavioral health care programs and hospice service agencies.

8. “Medication Management” means medication management services such as:

   a. Review of medication(s) side effects, and

   b. The adjustment of the type and dosage of prescribed medications.

9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
10. "Peer-and-Recovery Support" means intentional partnerships based on shared, lived experiences of living with behavioral health and/or substance use disorders to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.
11. "Peer Services" means supports intended for enrolled Members or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
12. "Planning Team" means a defined group of individuals that shall include the member/Responsible Person and with the

member's/Responsible Person's consent, their individual representative, Designated Representative (DR), and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

13. "Room and Board" means the amount paid for food and/or shelter. Medicaid funds can be expended for Room and Board when an individual lives in an institutional setting. Medicaid funds cannot be expended for Room and Board when a Member resides in an Alternative Home and Community Based Service (HCBS) Setting.
14. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, Peer-and-Recovery Support, Family

Support Services, care coordination activities and strategies to assist the Member in achieving an improved quality of life.

15. "Vocational Rehabilitation" means a program under Rehabilitation Services Administration (RSA) that provides a variety of services to persons with disabilities, with the goal to prepare for, enter into, or retain employment.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure medically necessary Title XIX/XXI Behavioral Health Services for Members eligible for ALTCS are covered as a health plan benefit.
2. The Division shall require providers utilize national coding standards including the use of applicable modifier(s) as listed in the AHCCCS Medical Coding Resources webpage and AHCCCS Behavioral Health Services Matrix.
3. The Division shall ensure medically necessary outpatient Behavioral Health Services are covered, regardless of a Member's diagnosis, so long as there are documented behaviors or symptoms that will benefit from Behavioral Health Services.

4. The Division shall ensure that Service Plan services are provided timely and in accordance with requirements included in AHCCCS Medical Policy Manual (AMPM) 320-0.
5. The Division shall ensure that services are not delayed or pended in order to have all team members present for a Service Planning meeting or until all team members are able to sign off on the Service Plan.
6. The Division shall require providers to make available and offer the option of having a Peer Recovery Support Specialist (PRSS) or Family Support Specialist for child or adult members and their families to provide covered services when appropriate.
7. The Division shall ensure policies and procedures are established by the AdSS to ensure Members on any form of Medication Assisted Treatment (MAT) are not excluded from services or admission to any treatment program or facility based upon the use of MAT.
8. The Division shall ensure emergency Behavioral Health Services are being provided, including crisis intervention services, without prior authorization being required.

9. The Division shall require that BHPs provide supervision to BHPPs and BHTs that provide services in the public behavioral health system.
10. The Division shall ensure that the BHPs providing Clinical Oversight of BHTs demonstrate the following key competencies:
    a. Knowledge of the relevant best clinical practices and policies that guide the services being provided,
    b. Knowledge of the policies and principles governing ethical practice,
    c. Ability to develop individualized BHT competency development goals and action steps to accomplish these goals, and
    d. Ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.
11. The Division shall ensure that Behavioral Health Services are provided to the Member's family members who consent to receiving these services, regardless of the family member's Title XIX/XXI entitlement status, as long as the Member's Service

Plan reflects that the provision of these services is aimed at accomplishing the Member's Service Plan goals.

12. The Division shall not require that the Member be present when the services are being provided to family members.
13. The Division shall allow as a covered service provided through indirect contact with Members includes:
    a. Email or phone communication, excluding leaving voicemails, specific to a Member's services;
    b. Obtaining collateral information; and
    c. Picking up and delivering medications. Refer to the AHCCCS behavioral health service matrix and AHCCCS medical coding resource webpage for requirements for billing and indirect contacts.
14. The Division shall not cover Room and Board except for inpatient hospitals, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID), and nursing facilities.
15. The Division shall ensure the referral process to initiate Behavioral Health Services meets the following requirements:
    a. A referral may be made, but is not required;

b. A Member, guardian, or designated representative may initiate requests;

c. If a provider's service array does not include a service required by a member, the provider shall make a referral to a provider with the member's assigned health plan, who does offer the necessary service; and

d. Comply with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, as applicable.

16. The Division shall ensure that transportation is provided as referenced in AMPM 310-BB.

17. The Division shall ensure that behavioral health providers are eligible to bill for travel per AMPM 310-B to provide a covered Behavioral Health Service. The Division shall ensure that behavioral health providers are adhering to the following travel limitations:

a. Provider travel mileage may not be billed separately except when it exceeds 25 miles,

b. When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip, and

c. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.

18. The Division shall ensure providers do not bill for travel for missed appointments. This includes time spent conducting outreach without successfully finding the Member and for time spent driving to do a home visit and the Member is not home.

B. COVERED BEHAVIORAL HEALTH SERVICES

1. The Division shall ensure the following treatment services are covered under the behavioral health benefit:

a. Assessment, non-court ordered evaluation, and screening services, when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate as specified in AMPM 320-U.

b. Behavioral health counseling and therapy when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate, and

c. Psychophysiological therapy and biofeedback when provided by qualified BHPs.

2. The Division shall ensure the following Rehabilitation Services are covered as a health plan benefit:

a. Skills training and development and psychosocial rehabilitation living skills training.

i. Skills training includes teaching independent living, social, and communication skills to Members or their families.

ii. Services may be provided to a Member, a group of individuals or their families with the Member(s) present.

iii. Skills training and development and psychosocial rehabilitation living skills training is provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or qualified BHT.

iv. More than one provider agency may bill for skills training and development services provided to a Member at the same time if indicated by the Member's clinical needs as identified in their Service Plan.

b. Cognitive rehabilitation

i. Provided by qualified BHP's to facilitate recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible.

ii. Goals of cognitive rehabilitation include:

1) Relearning of targeted mental abilities,

2) Strengthening of intact functions,

3) Relearning of social interaction skills,

4) Substitution of new skills to replace lost functioning, and

5) Controlling the emotional aspects of one's functioning.

iii. Training is done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects.

iv. Training is provided one on one and customized to each individual's strengths, skills, and needs.

c. Health promotion

i. Provided to educate and train about health-related topics to an individual or a group of people or their families.

ii. Presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as:

1) The nature of an illness,

2) Relapse and symptom management,

3) Medication management,

4) Stress management,

5) Safe sex practices,

6) Human Immunodeficiency Virus (HIV) education,

7) Parenting skills education, and

8) Healthy lifestyles.

iii. DUI health promotion education and training approved by Arizona Department of Health Services (ADHS), Division of Licensing Services (DLS).

iv. More than one provider agency may bill for health promotion provided to a Member at the same time if indicated by the Member's clinical needs as identified in their Service Plan.

d. Pre-Vocational Psychoeducational Services and ongoing support to maintain employment, post-vocational services, or job coaching that are designed to:

i. Assist Members to choose, acquire, and maintain employment or other meaningful community activity as outlined in AMPM 1240-J.

i. Prepare Members to engage in meaningful work-related activities, such as full- or part-time, competitive employment.

ii. Provided individually or in a group setting, but not telephonically and may include, but are not limited to the following:

1) Career or educational counseling;

2) Job training, assistance in the use of educational resources necessary to obtain employment;

3) Attendance to Vocational Rehabilitation Orientations;

4) Attendance to job fairs;

5) Assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills;

6) Professional decorum; and

7) Time management.

iv. Provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) DES-RSA, which is required to be the primary payer for Title XIX/XXI eligible individuals. The following services are not TXIX/TXXI covered treatment services:

1) Rehabilitative employment support assessments when available through the federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration,

2) Preparation of a report of a Member's psychiatric status for primary use with a court.

e. Ongoing support to maintain employment services

i. Post-vocational services, often called job coaching, which enable Members to maintain their current employment.

ii. Utilized when assisting employed Members with services traditionally used as pre-vocational in order to gain skills for promotional employment or alternative employment.

iii. Provided individually or in a group setting, as well as telephonically.

iv. Services may include, but are not limited to, the following:

1) Monitoring and supervision,

2) Assistance in performing job tasks, and

3) Supportive counseling.

f. Pre-vocational services and ongoing support to maintain employment to include the following:

i. Provided using tools, strategies, and materials which meet the Member's support needs;

ii. Services are tailored to support Members in a variety of settings;

iii. Service may be utilized for exploring strengths and interests when a Member is not ready to identify an educational or employment goal;

iv. Provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or Qualified BHTs; and

v. Billed by more than one provider agency for services provided to a Member at the same time, if indicated by the Member's clinical needs as identified in their Service Plan.

vi. For Community Service Agencies, see AMPM Policy 965 for further detail on service standards and provider qualifications for this service.

3. The Division shall ensure medical services provided or ordered within the scope of practice by a licensed physician, nurse practitioner, physician assistant, or nurse are covered as a health plan benefit to reduce a Member's symptoms and improve or maintain functioning.

a. For covered medications, the Division shall maintain its own formulary list to meet the unique needs of Members with behavioral health disorders. At a minimum, the Division formulary shall include all of the medications listed on the AHCCCS formulary per AMPM 310-V.

b. Laboratory, radiology, and medical imaging services shall be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice for screening, diagnosis or monitoring of a behavioral health condition.

    i. Laboratory services shall be provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, with the exception of specimen collections in a medical practitioner's office.

c. Medical management services shall be provided within the scope of practice by a licensed physician, nurse

practitioner, physician assistant or nurse to an individual as part of their medical visit for ongoing treatment purposes. Medical management includes:

1) Review of medication(s) side effects, and

2) The adjustment of the type and dosage of prescribed medications.

d. Outpatient Electroconvulsive Therapy (ECT) and outpatient Transcranial Magnetic Stimulation (TMS) performed by a physician within their scope of practice.

4. The Division shall ensure support services are covered as a health plan benefit to facilitate the delivery of or enhance the benefit received from other Behavioral Health Services and are provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs. Support services are classified into the following subcategories:

a. Provider Case management as specified in AMPM 570.

b. Personal care services which involve the provision of support activities that assist an individual in carrying out daily living activities.

i. May be provided in an unlicensed setting such as a Member's own home or community setting.

ii. Parents including natural parent, adoptive parent and stepparent may be eligible to provide personal care services if the Member receiving services is 21 years or older and the parent is not the Member's legal guardian.

iii. Personal care services provided by a Member's spouse are not covered.

iv. More than one provider agency may bill for personal care services provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

c. Home care training or Family Support Services which are directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the Member in the home and community.

i. Family Support Services involve activities to assist the family to adjust to the Member's illness, developing skills to effectively interact or guide the Member, understanding the causes and treatment of behavioral health issues, and understanding and effectively utilizing the healthcare system.

i. More than one provider agency may bill for family support provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

d. Peer Services which provide intentional partnerships based on shared lived experiences of living with behavioral health or substance use disorders, to provide social and personal support.

e. Therapeutic Foster Care (TFC) for Children as specified in AMPM 320-W and Adult Behavioral Health Therapeutic Home as specified in AMPM 320-X.

f. Unskilled respite care (respite) which provides an interval of rest or relief to a family Member or other individual

caring for the Member receiving Behavioral Health Services and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

i. The availability and use of informal supports and other community resources to meet the caregiver's respite needs shall be evaluated by the Division's Support Coordinator, and Provider Case Manager authorizing the respite services, in addition to formal respite services.

ii. The Service Plan shall identify if respite services will be provided by the behavioral health system or by the Division's Qualified Vendor system.

iii. Respite services are limited to 600 hours per year (October 1 through September 30) per person and are inclusive of both behavioral health and ALTCS respite care.

iv. Respite may include a range of activities to meet the social, emotional, and physical needs of the Member during the respite period. These services may be

provided on a short-term basis, a few hours during the day, or for longer periods of time involving overnight stays.

v. Respite services can be planned or unplanned. If unplanned respite is needed, the Division shall ensure the behavioral health provider assesses the situation with the caregiver and recommends the appropriate setting for respite.

vi. CSAs cannot provide respite services.

vii. Respite services covered as a behavioral health benefit may be provided in a variety of settings including:

1) Habilitation Provider,

2) Outpatient Clinic,

3) Adult Therapeutic Foster Care,

4) Behavioral Health Respite Homes,

5) Behavioral Health Residential Facilities,

6) Member's home, and

7) Community settings.

viii. A Member's Planning Team shall consider the appropriateness of the setting in which the recipient receives respite services:

1) When respite services are provided in a home setting, household routines and preferences shall be respected and maintained when possible.

2) The respite provider shall receive orientation from the family or caregiver regarding the Member's needs and the Service Plan.

3) Respite services, including the goals, setting, frequency, duration, and intensity of the service shall be defined in the Member's Service Plan.

4) Respite services are not a substitute for other covered services.

5) Summer day camps, day care, or other ongoing, structured activity programs are not respite unless they meet the definition or

criteria of respite services and the provider qualifications.

ix. Members who are parents and receive Behavioral Health Services receive necessary respite services for their non-enrolled children as indicated in their Service Plan, and

x. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

g. Permanent Supportive Housing (PSH) Support Services which provide flexible housing-based supports targeted towards individuals most at need based upon their health condition, housing status, and current or potential system costs.

i. Scope, frequency, delivery, and setting should be individualized to the Member's need, circumstances, and choice.

ii. Services shall be consistent with PSH evidence-based standard, nationally recognized or identified best practice.

iii. Services shall be voluntary to the Member.

iv. Staff providing these services shall be knowledgeable and provide services consistent with evidence-based practice for PSH models.

5. The Division shall ensure intensive outpatient and behavioral health day programs are covered as a health plan benefit and include the following:

a. Intensive outpatient treatment programs

i. Structured non-residential treatment programs that address mental health and substance use disorders through a combination of individual, group and family counseling and therapy and educational groups but do not require detoxification.

b. Behavioral Health Day Programs

i. Regularly scheduled program of individual, group or family services related to the Member's treatment

plan designed to improve the ability of the person to function in the community and may include the following rehabilitative and support services:

1) Skills training and development,
2) Behavioral health prevention or promotion,
3) Medication training and support,
4) Pre-vocational services and ongoing support to maintain employment,
5) Peer and Recovery Support, and
6) Home care training or Family Support.

ii. May be provided by either ADHS DLS licensed behavioral health agencies or Title XIX certified CSA.

iii. Staff members that deliver specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

iv. BHT's shall supervise behavioral health treatment and day programs provided by a CSA.

c. Therapeutic behavioral health day programs

i. Regularly scheduled program of active treatment modalities which may include services such as:

a) Individual, group or family behavioral health counseling and therapy;

b) Skills training and development;

c) Behavioral health prevention or promotion;

d) Medication training and support;

e) Pre-vocational services and ongoing support to maintain employment;

f) Homecare training or family support;

g) Medication monitoring;

h) Case management;

i) Peer and Recovery Support; and

j) Medical monitoring.

ii. Provided by an ADHS licensed behavioral health agency and in accordance with applicable service requirements set forth in A.A.C. Title 9, Chapter 10.

iii. Under the direction of a BHP.

iv. Staff members that deliver specific services within the therapeutic behavioral health day program shall meet the individual provider qualifications associated with those services.

v. Behavioral health day programs cannot be provided on the same day Day Treatment and Training is provided.

d. Community Psychiatric Supportive Treatment Program

i. Provide regularly scheduled program of active treatment modalities, including medical interventions, in a group setting and may include:

1) Individual, group or family behavioral health counseling and therapy;

2) Skills training and development;

3) Behavioral health prevention/promotion;

4) Medication training and support;

5) Ongoing support to maintain employment;

6) Pre-vocational services;

7) Home care training or Family Support,

8) Peer and Recovery Support; and

9) Other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

ii. Services are provided by an ADHS licensed behavioral health agency and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10.

iii. Programs shall be under the direction of a licensed physician, nurse practitioner or physician assistant.

iv. Staff members that deliver specific services within the medical behavioral health day program shall meet the individual provider qualifications associated with those services.

6. The Division shall ensure Behavioral Health Residential Facility Services are covered as a health plan benefit as specified in AMPM 320-V.

7. The Division shall ensure Behavior Analysis services are covered as a health plan benefit as specified in AMPM 320-S.

8. The Division shall ensure timely follow up and care coordination for Members after receiving crisis services as specified in AMPM 590.

10. The Division shall ensure Inpatient Services provided by ADHS licensed inpatient facilities are covered in accordance with A.A.C. R9-10-300 which provides a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services and are further classified into the following subcategories:

    a. Hospital services that provide continuous treatment with 24-hour nursing supervision and physicians on site and on call that includes:

        i. General psychiatric care,

        ii. Medical detoxification,

        iii. Forensic services in a general hospital,

        iv. A general hospital with a distinct psychiatric unit, or

        iv. A freestanding psychiatric facility.

            1) General and freestanding hospitals that provide services to Members if the hospital:

a) Meets the requirements of 42 CFR 440.10 and CFR Title 42, Chapter IV, Subchapter G, Part 482.

b) Is licensed pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. Title 9, Chapter 10.

2) Prior authorization is required for Bed Hold or Therapeutic Leave.

a) For Members age 21 and older, therapeutic leave may not exceed nine days, and Bed Hold days may not exceed 12 days, per contract year; and

b) For Members under 21 years of age, total therapeutic leave or Bed Hold days may not exceed 21 days per contract year.

b. Behavioral Health Inpatient Facilities (BHIF) which provide continuous treatment to a person who is experiencing acute and significant behavioral health symptoms. BHIFs may provide observation or stabilization services and child and adolescent residential treatment services, in addition

to other behavioral health or physical health services, as identified under their licensure capacity.

i. Observation or Stabilization Services

1) Services in addition to 24-hour nursing supervision and physicians on site or on call, include:

a) Emergency reception,

b) Screening,

c) Assessment,

d) Crisis intervention and stabilization,

e) Counseling, and

f) Referral to appropriate level of services or care. Refer A.A.C. R9-10- 1016 on facility-based crisis intervention services for more information.

2) Observation or stabilization services, within a BHIF, shall be provided according to the requirements in A.A.C. R9-10-1012 for outpatient treatment centers.

3) Facilities shall meet the requirements for reporting and monitoring the use of Seclusion and Restraint (S&R) as set forth in Arizona Administrative Code. The use of S&R Seclusion and Restraint shall only be used to the extent permitted by and in compliance with A.A.C. R9-21-204 and A.A.C. R9-10-316. For additional information and requirements regarding reporting and monitoring of seclusion and restraint, refer to AMPM 962.

ii. Partial Hospitalization programs (PHP) Include intensive therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

1) May include the following rehabilitative and support services:

a) Individual therapy,

b) Group and family therapy, and

c) Medication management

2) PHP service shall be provided by an appropriately licensed ADHS DLS Outpatient Treatment Center.

3) Staff who deliver the specific services shall meet the individual provider qualifications.

iii. Residential treatment services shall be accredited and shall meet the requirements for seclusion and restraint specified set forth in 9 A.A.C. R9-10-316 and in accordance with 42 CFR 441 and 42 CFR 483 if the facility has been authorized by ADHS DLS to provide seclusion and restraint.

1) Child and adolescent residential treatment services shall be provided by a BHIF to an individual who is under 18 years of age or under 21 years of age and meets the criteria in A.A.C. R9-10-318.

C. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Jul 26, 2023 16:09 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

Provider Travel

Provider travel is the cost associated with certain provider types traveling to provide a covered Behavioral Health Services. This is different than transportation, which is provided to take a Member to and from a covered Behavioral Health Services. Certain behavioral health professionals are eligible to bill for provider travel services as outlined below.

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service, therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160. When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.

- If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel

time and mileage is included in the rate and may not be billed separately.

- If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).
- If Provider C travels to multiple out-of-office settings (in succession), he/she shall calculate provider travel mileage by segment. For example:

  First segment = 15 miles, 0 travel miles are billed,

  Second segment = 35 miles, 10 travel miles are billed,

  Third segment = 30 miles, 5 travel miles are billed, and iv. Total travel miles billed = 15 miles are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

Provider Travel Limitations

If a BHP, BHT or BHPP travels to provide case management services, or provider type 85, 86, 87 or A4 travels to provide services to a client, and the client misses the appointment, the intended service may not be billed. Additionally, providers may not bill for travel for missed appointments. This applies for time spent conducting outreach without successfully finding the Member and for time spent driving to do a home visit and the Member is not home.

Skills Training

Examples of areas that may be addressed include self-care, household management, relationships, avoidance of exploitation, budgeting, recreation, development of social support networks, and use of individuals or their families with the Member(s) present.

Psychoeducational Services (pre-vocational services)

Psychoeducational Services are pre-vocational services that prepare Members to engage in meaningful work-related activities, such as full- or part-time, competitive employment. Such activities may include, but are not limited to, the following: career/educational counseling, job training,

assistance in the use of educational resources necessary to obtain employment, attendance to RSA Vocational Rehabilitation Orientations, attendance to job fairs, assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management.

Ongoing Support to Maintain Employment Services

Services may include, but are not limited to, the following: monitoring and supervision, assistance in performing job tasks, and supportive counseling. Ongoing Support to Maintain Employment can also be used.

Pre-vocational Services and Ongoing Support to Maintain Employment

While the goal may be for Members to achieve full-time employment in a competitive, integrated work environment, having other employment goals may be necessary prior to reaching that level.

Provider Case Management (provider level)

A supportive service provided to improve treatment outcomes. Examples of case management activities to meet Member's Service Plan goals include:

- Attendance and participation as a team Member in the Division's planning process including implementing the Planning Document/Service Plan,
- Assistance in maintaining, monitoring, and modifying Behavioral Health Services,
- Assistance in finding necessary resources other than Behavioral Health Services,
- Coordination of care as identified with the Planning Team, with the Member's healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community and other State agencies,
- If needed, and as identified by the Planning Team, coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services, and family counseling),

- Assisting Members in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach. SOAR activities may include:
    - Face-to-face meetings with Member,
    - Phone contact with Member, and
    - Face-to-face and phone contact with records and data sources (e.g., jail staff, hospitals, treatment providers, schools, Disability Determination Services, Social Security Administration, physicians).
- For provider case management used to facilitate a CFT, the modifier U1 is required and the claim must be submitted to the health plan the Member is enrolled with.
- SOAR services shall only be provided by staff who have been certified in SOAR through SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include:
    - Completion of SOAR paperwork without Member present,
    - Copying or faxing paperwork,

- Assisting Members with applying for benefits without using the SOAR approach, and
- Email

For provider case management utilized when assisting Members in applying for Social Security benefits (using the SOAR approach) the modifier HK is required. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service. Claims must be submitted to the health plan the Member is enrolled with.

Outreach and follow-up of crisis contacts and missed appointments, and Participation in staffing, case conferences, or other meetings with or without the Member or their family participating.

Case Management Limitations

Billing for case management is limited to providers who are directly involved with providing services to the Member.

Provider Case management services provided by licensed inpatient, behavioral health residential facility or day program providers are included in

the rate for these settings and cannot be billed separately; however, providers other than the inpatient, behavioral health residential facility or day program can bill case management services provided to the Member, iii. A single practitioner may not bill case management simultaneously with any other service.

For assessments, the provider may bill all time spent in direct or indirect contact (e.g., indirect contact may include email or phone communication specific to a Member's services) with the Member and other involved parties involved in implementing the Member's Treatment/Service Plan.

More than one provider agency may bill for case management at the same time, if it is clinically necessary and documented within the Member's Treatment/Service Plan. More than one individual within the same agency may bill for case management at the same time, if it is clinically necessary and documented within the Member's Treatment/Service Plan.

When a provider is picking up and dropping off medications for more than one Member, the provider shall divide the time spent and bill the appropriate case management code for each involved Member.

Peer and Recovery Support

Assists Members with accessing services and community supports, partnering with professionals, overcoming service barriers, and/or understanding and coping with the stressors of the Member's behavioral health condition. These services are aimed at assisting in the creation of skills to promote long-term sustainable recovery. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family or community level. Peer and Recovery Support is intended for enrolled members and their families who require greater structure and intensity of services than those available through informal community-based support groups (e.g., 12-Step Programs, SMART Recovery).

310-C BREAST RECONSTRUCTION AFTER MASTECTOMY

EFFECTIVE DATE: October 26, 2022
REFERENCES: 42 U.S. Code § 300gg-52, A.A.C. R9-22-205, AMPM Policy 820

PURPOSE

This policy describes covered breast reconstruction surgery services following a mastectomy for DDD members who are eligible for ALTCS.

DEFINITIONS

1. "Contralateral" means relating to or denoting the side of the body opposite to that on which a particular structure or condition occurs.

POLICY

A. COVERED SERVICES

1. The Division shall cover breast reconstructive surgery post-mastectomy per 42 U.S. Code § 300gg-52.
2. The Division shall cover reconstructive breast surgery of the unaffected contralateral breast following mastectomy if required to achieve relative symmetry with the reconstructed affected breast.

3. The Division shall cover breast reconstruction surgery either immediately following the mastectomy or after the breast reconstruction, based on the choice of the member.
4. The Division shall cover medically necessary breast implant removal when the original implant was the result of a medically necessary mastectomy.
5. The Division shall cover an external prosthesis, including a surgical brassiere, for DDD Long Term Care members who choose not to have breast reconstruction post-mastectomy, or who choose to delay breast reconstruction until a later time.
6. The Division shall require Prior Authorization (PA) from the AHCCCS Division of Fee-For-Service Management to be obtained for breast reconstruction surgery provided to Tribal Health Program members.

B. LIMITATIONS

1. The Division shall not cover services provided solely for cosmetic purposes, per A.A.C. R9-22-205. If a member has had a breast implant procedure for cosmetic purposes, (i.e., augmentation),

not related to a mastectomy, medically necessary removal of the implant is covered, but implant replacement is not covered.

Signature of Chief Medical Officer: Anthony Dekker (Oct 19, 2022 10:26 PDT)
Anthony Dekker, D.O.

310-D1 EMERGENCY DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

EFFECTIVE DATE: July 19, 2023
REFERENCES: A.R.S. § 32-1207 and 32-1231; AMPM 310-D1

PURPOSE

This policy establishes requirements for the provision of medically necessary dental services for Members of the Division of Developmental Disabilities (Division) who are age 21 and older.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection due to pathology or trauma.
2. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,

e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

7. "Simple Restoration" means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns.

POLICY

A. GENERAL COVERED DENTAL SERVICES

1. The Division shall require the following dental services are covered and provided by a licensed Dental Provider for Members who are 21 years of age or older:
    a. Emergency dental services up to $1,000 per Member per contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
    b. Medical and surgical services furnished by a Dental Provider when:
        i. The services may be performed under state law either by a physician or by a Dental Provider, and
        ii. The services would be considered a Physician Service if furnished by a physician.
2. The Division shall ensure emergency services relate to treatment of the following medical conditions:
    a. Acute pain,
    b. Infection, or
    c. Fracture of the jaw.

3. The Division shall ensure the following emergency services, which are not subject to the $1,000 adult emergency dental limit, are covered:
   a. Limited problem focused examination of the oral cavity,
   b. Required radiographs,
   c. Complex oral surgical procedures such as treatment of maxillofacial fractures,
   d. Administration of an appropriate anesthesia, and
   e. Prescription of pain medication and antibiotics.
4. The Division shall not cover the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) except for reduction of trauma. This item is not subject to the $1,000 adult emergency dental limit.
5. The Division shall ensure the following limited dental services, which are not subject to the $1,000 adult emergency dental limit, are covered for Members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation:

a. Elimination of oral infections and the treatment of oral disease, which include:

i. Dental cleanings,

ii. Treatment of periodontal disease,

iii. Medically necessary extractions, and

iv. Provision of Simple Restorations.

6. The Division shall ensure services outlined in subsection (5) of this section are covered only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. The Division shall ensure prophylactic extraction of teeth are covered in preparation for radiation treatment of cancer of the jaw, neck or head. This item is not subject to the $1,000 adult emergency dental limit.

8. The Division shall ensure cleanings for Members who are in an inpatient hospital setting and experiencing the following are covered:

a. Placed on a ventilator, or

b. Physically unable to perform oral hygiene.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR PERSONS AGE 21 AND OLDER

1. The Division shall ensure medically necessary emergency dental care and extractions are covered for persons aged 21 years and older who meet the criteria for a Dental Emergency.
2. The Division shall ensure the following services and procedures are covered as emergency dental services:
    a. Emergency oral diagnostic examination;
    b. Radiographs and laboratory services, limited to the symptomatic teeth;
    c. Composite resin due to recent tooth fracture for anterior teeth;
    d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
    e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
    f. Pulp cap, direct or indirect plus filling;
    g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative/sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection, including:

   i. Periapical and periodontal infections, and

   ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. The Division shall ensure follow-up procedures needed to stabilize teeth due the emergency services are covered, and subject to the $1,000 limit.

C. ADULT EMERGENCY DENTAL SERVICES LIMITATIONS FOR PERSONS AGE 21 YEARS AND OLDER

1. The Division shall not cover the following adult dental services:
    a. Maxillofacial dental services provided by a Dental Provider, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible;
    b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;
    c. Routine restorative procedures and routine root canal therapy;
    d. Treatment for the prevention of pulpal death and imminent tooth loss, except for:
        1. Non-cast fillings,
        2. Crowns constructed from pre-formed stainless steel,
        3. Pulp caps, and

4. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. DIVISION AND FFS PROGRAM RESPONSIBILITIES

1. The Division shall require the AdSS to provide the following:

a. Coordination of covered dental services for enrolled Division Members;

b. Documentation of current valid contracts with Dental Providers who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to need emergency dental services, or Members may self-refer to a Dental Provider when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. The Division shall ensure the annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers between AdSS's or between Fee-For-Service (FFS) and an AdSS.
3. The Division shall ensure dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
4. The Division shall require the AdSS or Tribal Case Manager transferring the Member notifies the accepting entity regarding the current balance of the dental benefit.
5. The Division shall require the relinquishing AdSS to use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
   a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental

Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;.

b. The Member is not permitted to carry-over unused benefit from one year to the next; and

c. A year begins on October 1st and ends September 30th.

6. The Division shall not require prior authorization for emergency dental services for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure emergency dental services of $1,000 per contract year for Members age 21 years and older are covered. Billing of Division Members for emergency dental services in excess of the $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute Members, and A.A.C. R9-28-701.10 for ALTCS Members.

2. The Division shall ensure providers who bill Members for emergency dental services exceeding the $1,000 limit conduct the following:

a. The provider must first inform the Member or Responsible Person in a way they understand, that the requested dental service exceeds the $1,000 limit and is not covered by the Division;

b. The provider must furnish the Member or Responsible Person with a document to be signed in advance of the service stating that the Member understands that the dental service will not be fully paid by the Division;

c. The document shall contain information describing the type of service to be provided and the charge for the service;

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division; and

e. The Member must sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. The Division shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

i. An ambulatory service center, or

ii. An outpatient hospital.

b. Anesthesia is required as part of the emergency service.

2. The Division shall require Dental Providers performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

3. The Division shall require Physicians performing GA on Members for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. The Division shall require providers to complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.

2. The Division shall require Informed Consents for oral health treatment include the following:

a. A written consent for examination or any treatment measure, which does not include an irreversible procedure;

b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment;

c. A separate written consent is completed for:

   i. Any irreversible procedures,

   ii. Invasive procedures,

   iii. Dental fillings, or

   iv. Pulpotomies.

d. Consent is used in a manner that protects the Member and is easily understood by the:

   i. Member,

   ii. Guardian, or

   iii. Designated representative.

e. A written treatment plan must be reviewed and signed by a Responsible Person with the Member;

f. Consents and treatment plans must be:

   i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age, or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

h. Extends to all Contractor mobile unit providers.

3. The Division shall require completed consents and treatment plans be maintained in the Members chart and are subject to audit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:15 PDT)
Anthony Dekker, D.O.

310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT ROUTINE DENTAL SERVICES

EFFECTIVE DATE: July 19, 2023
REFERENCES: AMPM 310-D2

PURPOSE

This Policy establishes requirements regarding the provision of medically necessary dental services for members in the Arizona Long Term Care Program (ALTCS).

DEFINITIONS

1. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,
    e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

2. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.
3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following medically necessary dental benefits are covered up to $1,000 per member per contract year for ALTCS members age 21 or older in accordance with A.R.S. § 36-2939:

a. Diagnostic care,

b. Therapeutic care, and

c. Preventative care, including dentures.

2. The Division shall refer to AMPM 430 for dental services for Members under the age of 21.

3. The Division shall require emergent services for Members are covered as specified in AMPM 310-D1. These services do not count towards the ALTCS $1,000 limit.

B. DIVISION OVERSIGHT

1. The Division shall ensure the following is provided:

a. Coordination of covered dental services for enrolled members;

b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);

c. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

d. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The Division shall require primary care providers initiate member referrals to dentist(s) when the member is determined to be in need of dental services. Members may also self-refer to a dentist when in need of dental services.
3. The Division shall ensure the annual dental benefit limit remains with the Member is the Member transfers to the following:
    a. Between one AdSS to another, or
    b. Between Fee-For-Service and an AdSS.
4. The Division shall require the transferring AdSS notifies the receiving AdSS regarding the current balance of the Member's dental benefit.
5. The Division shall ensure the AdSS utilizes the ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9, must be utilized for reporting any dental benefit balance.
6. The Division shall ensure dental services provided to American Indian/Alaska Native members within an Indian Health Service (IHS) or 638 Tribal Facility are also not subject to the ALTCS dental benefit $1,000 limit.

7. The Division shall require the Member is aware they are not permitted to carry-over unused benefit from one contract year to the next.
8. The Division shall refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies to ensure frequency limitations and services that require prior authorization are met as specified in AMPM 431.

C. FACILITY AND ANESTHESIA CHARGES

1. The Division shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:
   a. A member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in an ambulatory surgery service center or an outpatient hospital, and
   b. Anesthesia is required as part of the routine service.
2. The Division shall require dentists performing General Anesthesia (GA) on members shall bill using dental codes and the cost will count towards the $1,000 limit.

D. INFORMED CONSENT

1. The Division shall require providers complete the appropriate informed consents and treatment plans for Members, in order to provide quality and consistent care.
2. The Division shall require informed consents for oral health treatment include the following:
    a. A written consent for examination or any treatment measure, which does not include an irreversible procedure,
    b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment,
    c. A separate written consent is completed for:
        i. Irreversible procedures,
        ii. Invasive procedures,
        iii. Dental fillings, or
        iv. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.
    d. Consent is used in a manner that protects the Member and is easily understood by the:

i. Member,

ii. Guardian, or

iii. Responsible Person.

e. A written treatment plan must be reviewed and signed by the Responsible Person with the Member,

f. Consents and treatment plans must be:

i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age; or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

3. The Division shall require completed consents and treatment plans are maintained in the Members chart and are subject to audit.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure medically necessary services are provided within the $1,000 dental benefit allowable amount.
2. The Division shall ensure services are provided as set forth in A.A.C. R9-28-701(10) and R9-22-702, when medically necessary services are greater than $1,000.
3. The Division shall require the following notification when the provider informs the Member that the dental service requested is not covered and exceeds the $1,000 limit:
    a. Verbally,
    b. In writing, and
    c. In the member's primary language.
4. The Division shall require the following if the Member agrees to pursue the receipt of services:
    a. The provider shall supply the member a document describing the service and the anticipated cost of the service, and
    b. Prior to service delivery, the Member must sign and date a document indicating that they understand that they will be

responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 11, 2023 16:25 PDT)

Anthony Dekker, D.O.

310–E DIALYSIS

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers hemodialysis and peritoneal dialysis are covered services when provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests), and drugs medically necessary for the dialysis treatment are covered.

A. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for the following:

   1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

   2. Division-covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program

   3. Placement, replacement, or repair of the chronic dialysis route.

B. Hospital admissions solely to provide chronic dialysis are not covered.

C. Hemoperfusion is covered when medically necessary.

310-H HEALTH RISK ASSESSMENT AND SCREENING TESTS

EFFECTIVE DATE: MAY 13, 2016

A. The Division covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members.

B. These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status. Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program.

C. Preventive health risk assessment and screening test services are covered for adults, except when the adult member is hospitalized. Services include, but are not limited to:

1. Hypertension screening (annually).

2. Cholesterol screening (once, additional tests based on history).

3. Routine mammography annually after age 40 and at any age if considered medically necessary.

4. Cervical cytology, including pap smears (annually for sexually active women; after three successive normal exams the test may be less frequent).

5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50).

6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history).

7. Tuberculosis screening (once, with additional testing based on history, or, for members residing in a facility, as necessary per health care institution licensing requirement).

8. HIV screening.

9. Immunizations (See AHCCCS Policy AMPM 310 M for details).

10. Prostate screening (annually after age 50; and, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and

11. Physical examinations (includes well visits and well exams), periodic health

examinations or assessments, diagnostic work ups or health protection packages designed to:

a. Provide early detection of disease,

b. Detect the presence of injury or disease,

c. Establish a treatment plan,

d. Evaluate the results or progress of a treatment plan or the disease, or

e. Establish the presence and characteristics of a physical disability, which may be the result of disease or injury.

D. Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Exclusions

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

A. Qualification for insurance.

B. Pre-employment physical examination.

C. Qualifications for sports or physical exercise activities.

D. Pilots examinations (Federal Aviation Administration).

E. Disability certification for the purpose of establishing any kind of periodic payments.

F. Evaluation for establishing third party liability.

310-I HOME HEALTH SERVICES

REVISION DATE: 12/07/2022, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.R.S. § 32-1601, A.R.S. §36-2939, 42 CFR 440.70, AMPM 310-I, AMPM Policy 1240-G

PURPOSE

This policy describes and establishes requirements for covered Home Health Services for Division of Developmental Disabilities (Division) members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Face-to-Face Encounter" means a Face-to-Face visit, in person or via telehealth, with a member's Primary Care Physician (PCP) or physician of record, related to the primary reason the member requires Home Health Services (42 CFR 440.70).
2. "Home Health Agency (HHA)" means a public or private agency or organization, or part of an agency or organization, that is licensed by the State and meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28 (42

CFR 440.70).

3. "Home Health Services" means nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances provided to a member at their place of residence and on the member's physician's orders, or ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and reviewed by the practitioner annually as part of a written plan of care.

4. "Licensed Health Aide (LHA)" means a person who is licensed to provide or assist in providing nursing-related services and:

   a. Is the parent, guardian, or family member of the Arizona Long Term Care System (ALTCS) member who is under 21 years of age and eligible to receive Skilled Nursing or skilled nursing respite care services who may provide Licensed Health Aide (LHA) services only to that member and only consistent with that member's plan of care; and

   b. Has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration,

tracheostomy care, enteral care and therapy, and any other tasks approved by the State Board of Nursing in rule.

POLICY

A. HOME HEALTH AGENCIES

1. The Division shall cover Home Health Services that are medically necessary and provided by a Medicare Certified Home Health Agency (HHA) licensed by the Arizona Department of Health Services (ADHS) that is contracted by the Division. All other requirements of 42 CFR 440.70 apply; however, intermittent nursing services shall be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).
2. The Division shall permit a non-Medicare certified, State certified HHA or an Arizona Health Care Cost Containment System (AHCCCS) registered Independent RN to provide Home Health Services only under the following circumstances:
   a. Intermittent nursing services are needed in a geographic service area not currently served by a Medicare certified HHA;

b. The Medicare certified HHA in the applicable geographic service area lacks adequate staff to provide the necessary services for the member(s); or

c. The Medicare certified HHA is not willing to provide services to, or contract with the Division .

3. The Division shall permit Home Health Services provided by a non-Medicare State certified HHA or AHCCCS registered Independent RN when the following apply:

a. Non-Medicare certified HHAs shall be licensed by the State and:

i. The Division shall maintain documentation supporting at least one of the three circumstances specified in subsections (2)(a), (b) and (c) above;

ii. The State licensed HHA shall be an AHCCCS registered provider which employs the individuals providing Home Health Services; and

iii. Intermittent nursing services shall be provided by an RN who is employed by the State licensed HHA.

b. Independent RNs shall be registered as an AHCCCS registered provider and:

i. Shall receive written orders from the member's PCP or physician of record, are responsible for all documentation of member care;

ii. Are responsible for the transmission of said documentation to the member's PCP or physician of record; and

iii. Sub-contractors who contract with Independent RNs to provide home health skilled nursing shall develop oversight activities to monitor service delivery and quality of care provided by the Independent RN.

B. INTERMITTENT NURSING AND HOME HEALTH AIDE SERVICES

1. The Division shall cover nursing services that are provided on an intermittent basis as ordered by a treating physician.
2. The Division shall require that home health aides provide non-skilled services under the direction and supervision of an RN.
3. The Division shall cover home health aide services in units of one

visit. Visits include at least one of the following components:

a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the member;

b. Monitoring and documenting of member vital signs, as well as reporting results to the supervising HHA RN, PCP or physician of record;

c. Providing members with personal care;

d. Assisting members with bowel, bladder and/or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Assisting members with self-administration of medications;

f. Assisting members with eating, if required, to maintain sufficient nutritional intake, and providing information about nutrition;

g. Assisting members with routine ambulation, transfer, use of special appliances and/or prosthetic devices, range of

motion activities or simple exercise programs;

h. Assisting members in activities of daily living to increase member independence;

i. Teaching members and families how to perform home health tasks; and

j. Observation of and reporting to the HHA Provider or the support coordinator for members who exhibit the need for additional medical or psychosocial support, or a change (decline or improvement) in condition during the course of service delivery.

4. The Division shall cover intermittent nursing services only when provided by an RN or LPN under the supervision of an RN or PCP or physician of record as specified in A.A.C. R4-19-401.

5. The Division shall cover intermittent nursing services provided by an LPN only if they are working for an HHA.

6. The Division shall cover intermittent nursing services in 15 minute units, not to exceed two hours (eight units) per single visit.

7. The Division shall not cover more than four hours (16 units) per calendar day.
8. The Division shall cover intermittent nursing services to members residing in an Assisted Living Facility (ALF) when skilled nursing services are not included in the facility's per diem rate.
9. The Division shall cover home health aide services provided by a family member, including but not limited to parents and guardians of minor children or adults when the individual is a Licensed Nursing Assistant (LNA) and employed by a Medicare Certified HHA.

C. LICENSED HEALTH AIDE

1. The Division shall cover LHA services in units of one visit that include one or more of the following:
   a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the member;
   b. Monitoring and documenting of member vital signs, as well

as reporting results to the supervising RN, PCP or physician of record;

c. Providing members with personal care;

d. Assisting members with bowel, bladder and/or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Administering or assisting members with self-administration of medications;

f. Assisting members with eating if required, to maintain sufficient nutritional intake and providing information about nutrition;

g. Assisting members with routine ambulation, transfer, use of special appliances and/or prosthetic devices, range of motion activities or simple exercise programs;

h. Assisting members in activities of daily living to increase member independence;

i. Teaching members and families how to perform home health tasks; and

j. Observation and reporting to the HHA Provider and/or the support coordinator of members who exhibit the need for additional medical or psychosocial support or a change (decline or improvement) in condition during the course of service delivery.

D. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES

1. The Division shall cover physical therapy, occupational therapy, and speech therapy services provided by an HHA for members as specified in AMPM Policy 310-X.

E. MEDICAL EQUIPMENT, APPLIANCES AND SUPPLIES

1. The Division shall cover medical equipment, appliances, and supplies provided by an HHA as specified in AMPM Policy 310-P.

F. FACE-TO-FACE ENCOUNTER REQUIREMENTS

1. The Division shall require the practitioner to complete a

Face-to-Face encounter with Tribal Health Program members for initiation of Home Health Services, that relates to the primary reason the member requires Home Health Services no more than 90 days before or within 30 days after start of services.

2. The Division shall require the Face-to-Face encounter for Tribal Health Program members be conducted by one of the following:
   a. The ordering PCP or physician of record or
   b. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.
3. The Division shall allow the practitioner to perform the Face-to-Face encounter for Tribal Health Program members to occur through telehealth.

Signature of Chief Medical Officer: Anthony Dekker (Nov 29, 2022 09:27 MST)
Anthony Dekker, D.O.

310–J HOSPICE SERVICES

REVISION DATE: 5/8/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, and Arizona's Section 115(a) Medicaid Demonstration Extension.

This Policy establishes requirements for Hospice Services. Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member's own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital

B. Nursing care institution

C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Bereavement Counseling - Emotional, psychosocial, and spiritual support and services provided before and after the death of a member to assist the family with issues related to grief, loss, and adjustment.

B. Continuous home care - Services provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous) to maintain residence in their own home as specified in 42 CFR 418.204(a). Care must be predominantly nursing care, provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Homemaker and home health aide services may also be provided to supplement the care.

C. Palliative care - Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering and is provided to address physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

D. Period of crisis - A period (up to 24 hours per day) in which the hospice-eligible member

requires continuous care to achieve palliation or management of acute medical symptoms.

E. Terminally ill - A medical prognosis of life expectancy for six months or less if the illness runs its normal course.

Policy

Hospice Care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide palliative and support care for terminally ill members and their family members and caregivers for the physical, psychosocial, spiritual, and emotional needs as delineated in a specific patient plan of care.

Hospice Services are covered for all terminally ill members who meet the specified medical criteria and requirements under A.R.S. §§ 36-2907, 36-2939, and 36-2989, and 42 CFR Part 418 et seq.

In order to receive Hospice Care, Members must waive the right to duplicative services including: hospice care provided by a non-designated hospice service; services that are related to the treatment of the terminal condition or a related condition, unless provided by the designated hospice, provided by the attending physician, or provided as room and board by a nursing facility where the member is a resident as specified in CMS Medicaid Manual section 4305.2. This waiver does not apply to EPSDT-aged members.

If the Hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor however must report such cases to ADHS as the hospice licensing agency in Arizona.

A. Eligibility

1. A physician must provide a signed certification stating that the member's prognosis is terminal, with the member's life expectancy not exceeding six months. However, due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months, provided additional physician certifications are completed.

2. A member may elect to receive Hospice Care during one or more of the following election periods:

   a. An initial 90-day period,

   b. A subsequent 90-day period, or

   c. An unlimited number of subsequent 60-day periods.

3. As specified in Section 2302 of the Affordable Care Act, EPSDT-aged members may continue to receive curative treatment for a terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care related to the terminal diagnosis but may continue to receive services unrelated to the hospice diagnosis.

B. Hospice Services

Hospice services provide palliative and support care for terminally ill members and

their family members and caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. When the conditions of participation are met as specified in 42 CFR Part 418, hospice services are provided in the member's own home, or the following inpatient settings:

1. Hospital.

2. Nursing care institution.

3. Free standing Hospice Unit.

Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services available as necessary to meet the member's needs. The following bundled hospice services are covered when provided in approved settings:

1. Physicians' services for the treatment of the member's terminal illnesses and related administrative and general supervisory activities, except for attending physician services provided by non-hospice employees;

2. Continuous Home Care;

3. Dietary services, which include a nutritional evaluation and dietary counseling when necessary;

4. Home health aide services;

5. Homemaker services;

6. Nursing services provided by or under the supervision of a registered nurse;

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field and who is appropriately licensed or certified;

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting;

9. Routine Home Care;

10. Social services provided by a qualified social worker;

11. Therapies that include physical, occupational, or speech therapy;

12. A 24 hour on-call availability to provide services such as reassurance, information, and referral for members and family members and caregivers;

13. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee. Under 42 C.F.R. 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services;

14. Medical supplies, appliances, and equipment, including:

    a. Pharmaceuticals, which are used in relationship to the palliation or management of the member's terminal illness; and

    b. Medical equipment and appliances may include but are not limited to:

        i. Wheelchairs,

        ii. Hospital beds, and

        iii. Oxygen equipment.

15. Bereavement counseling to the member's family and caregiver both before and up to 12 months following the death of that member. Bereavement Counseling, to the member's family and caregiver both before and up to 12 months following the death of the member, is part of the bundled hospice services and is not separately reimbursable, as specified in 42 CFR 418.204.30.

310-K HOSPITAL INPATIENT SERVICES

REVISION DATE: 11/29/2018, 11/17/2017, 7/3/2015, 3/2/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 32-801 through 871

The Division of Developmental Disabilities (Division) covers medically necessary inpatient hospital services, provided by a licensed participating hospital, for all members eligible for ALTCS. Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

Inpatient hospital services for members include, but are not limited to, the following:

A. Hospital accommodation, and appropriate staffing, supplies, equipment and services for any or all of the following:

1. Acute physical care and behavioral health care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living asneeded
8. Medical detoxification and treatment services
9. Behavioral health forensic services
10. Dietary services
11. Medical supplies, appliances and equipment consistent with the level of accommodation
12. Perfusion and perfusionist services.

B. Ancillary Services

Ancillary services include any or all of the following:

1. Audiology services
2. Chemotherapy

3. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

4. Dental surgery for members 21 years of age and older within limitations as described in Division Medical Policy 310-D

5. Dialysis

6. Laboratory services

7. Pharmaceutical services and prescribed drugs

8. Radiological and medical imaging services

9. Rehabilitation services including physical, occupational and speech therapies

10. Respiratory therapy

11. Behavioral health assessments, and behavioral health therapy (including electroconvulsive therapy)

12. Services and supplies necessary to store, process, and administer blood and blood derivatives

13. Total parenteral nutrition

14. Wound care.

Limitations and Exclusions

The Division covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

The Division does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.

310-L HYSTERECTOMY

REVISION DATE: 2/7/2024
REVIEW DATE: 7/3/2023
EFFECTIVE DATE: November 17, 2017
REFERENCES: 42 CFR 441.250 et seq, 42 CFR 441.251, 42 CFR 441.255, AMPM 820.

PURPOSE

This Policy establishes the requirements for coverage of Hysterectomy services in accordance with 42 CFR 441.250 et seq for Members within the Division of Developmental Disabilities who seek to obtain a medically necessary Hysterectomy.

DEFINITIONS

1. "Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus as specified in 42 CFR 441.251.

2. "Initial Medical Acknowledgement" means documentation of the Member's understanding prior to surgery, the procedure will render them sterile.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

5. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

6. "Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing as specified in 42 CFR 441.251.

POLICY

A. CONDITIONS WHEN A HYSTERECTOMY SHALL BE COVERED IF DEEMED MEDICALLY NECESSARY

1. The Division shall cover a Hysterectomy for the following conditions when medically necessary:

   a. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding, when medical and surgical therapy has failed, and childbearing is no longer a consideration;

   b. Endometriosis, with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy; or

   c. Uterine Prolapse, when childbearing is no longer a consideration and for whom non-operative or surgical correction, suspension or repair, will not provide the Member adequate relief.

B. CONDITIONS WHERE MEDICAL OR SURGICAL INTERVENTION IS NOT REQUIRED PRIOR TO HYSTERECTOMY

1. The Division shall cover medically necessary Hysterectomy services without prior trial of medical or surgical intervention in the following cases:
   a. Invasive carcinoma of the cervix;
   b. Ovarian carcinoma;
   c. Endometrial carcinoma;
   d. Carcinoma of the fallopian tube;
   e. Malignant gestational trophoblastic disease;
   f. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy;
   g. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption; or
   h. Other potentially life threatening conditions where removal of the reproductive organs is necessary and considered the standard of care.
2. The Division shall require the provider to complete AMPM

Attachment 820-A prior to performing Hysterectomy procedures.

C. MEDICAL ACKNOWLEDGEMENT AND DOCUMENTATION

1. The Division shall require providers comply with the following requirements prior to performing the Hysterectomy:
   a. Inform the Responsible Person both orally, in the Member's medical records and in AMPM Attachment 820-A that the Hysterectomy will render the Member incapable of reproducing, resulting in sterility;
   b. Obtain from the Responsible Person a signed and dated written acknowledgment stating that the information in AMPM Attachment 820-A has been received and that the individual has been informed and understands that the Hysterectomy will result in sterility.
2. The Division shall require the Primary Care Provider (PCP) keep a signed, and dated written acknowledgment in the Member's medical records.

3. The Division shall require providers use AMPM Attachment 820-A as specified in AMPM 820.

D. EXCEPTIONS FROM INITIAL MEDICAL ACKNOWLEDGEMENT

1. The Division shall not require the physician performing the Hysterectomy to obtain Initial Medical Acknowledgment in either of the following situations:
   a. The Member was already sterile before the Hysterectomy.
      i. In this instance the physician must certify in writing that the Member was already sterile at the time of the Hysterectomy and specify the cause of sterility.
      ii. Documentation shall include the specific tests and test results conducted to determine sterility if the cause of sterility is unknown; or
   b. The Member requires a Hysterectomy because of a life-threatening emergency situation in which the physician determines that Initial Medical Acknowledgement is not possible. In this circumstance, the physician must certify

in writing that the Hysterectomy was performed under a life-threatening emergency situation in which the physician determined that Initial Medical Acknowledgement was not possible.

2. The physician shall include a description of the nature of the emergency in the Member's medical record and when AMPM Attachment 820-A is submitted to AHCCCS.

E. LIMITATIONS

1. The Division shall not cover a Hysterectomy if:
   a. It is performed solely to render the individual permanently incapable of reproducing; or
   b. There was more than one purpose to the procedure, and the procedure would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

F. SECOND LEVEL REVIEW

1. The Division Medical Director shall:

   a. Complete a Second Level Review of all approvals or denials for all requests for Hysterectomies for Members prior to the completion of the procedure, except in the event of a life-threatening emergency situation;

   b. Ensure all life-threatening emergency Hysterectomy cases are submitted to the Division for retrospective review;

   c. Consult with the AHCCCS Medical Director for Tribal Health Plan (THP) or the assigned AdSS health plan's Medical Director when there are questions regarding the Hysterectomy; and

   d. Have the final authority to approve or deny a Hysterectomy, except in the event of a life-threatening emergency situation.

G. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

Coverage of Hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis. Prior to

performing a Hysterectomy, providers shall establish medical necessity in part by providing documentation relating to the trial of medical or surgical therapy which has not been effective in treating the Member's condition. The length of such trials shall also be documented in the Member's medical records.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:24 MST)
Anthony Dekker, D.O.

310-M IMMUNIZATIONS

REVISION DATE: 05/10/2023, 10/26/2022, 04/24/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. § 32-1974, AMPM 310-V, AMPM 430

PURPOSE

The purpose of this policy is to describe covered immunization services for DDD members who are eligible for ALTCS.

DEFINITIONS

1. "Adult" means an individual 18 years of age and older.
2. "Child" means an individual under the age of 18 years.
3. "Immunization" means the administration of a vaccine to promote the development of immunity or resistance to an infectious disease.
4. "Vaccine" means the preparation administered to stimulate the production of antibodies and provide immunity against one or several diseases.

POLICY

A. COVERAGE

1. The Division shall allow pharmacists and pharmacy interns under the supervision of a pharmacist, within their scope of practice, to administer AHCCCS covered immunizations to adults 19 years and older as specified in A.R.S. § 32-1974.
2. The Division shall cover immunizations as appropriate for age, history, and health risk, for adults and children.
3. The Division shall follow recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP).
4. The Division shall not require prior authorization for medically necessary covered immunizations when administered by an AHCCCS-registered provider.
5. The Division shall cover immunizations for adults that include, but are not limited to:
    a. Diphtheria-tetanus,
    b. Influenza,

c. Coronavirus Disease 2019 (COVID-19),

d. Pneumococcus,

e. Rubella,

f. Measles,

g. Hepatitis A,

h. Hepatitis B,

i. Pertussis,

j. Zoster vaccine, for members 50 years of age and older,

k. Human Papillomavirus (HPV) vaccine.

6. The Division shall cover vaccinations for children as described in AMPM 430.

7. The Division shall not cover immunizations for members for passport, visa clearance, or for travel outside of the United States.

8. The Division shall cover pharmacy reimbursement for adult immunizations as described in AMPM 310-V.

Signature of Chief Medical Officer: Anthony Dekker (May 4, 2023 10:39 PDT)
Anthony Dekker, D.O.

310-N LABORATORY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner, or dentist upon referral by a PCP, and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers, shall qualify as covered services if medically necessary.

Clinical laboratory, radiological, and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

310-P MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND PROSTHETIC DEVICES (ACUTE CARE SERVICES)

REVISION DATE: 3/25/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: §36-2907; Laws 2015, Chapter 264, Section 3 (HB 2373); §36-2907.

A. Medical supplies, durable medical equipment (DME) orthotic and prosthetic devices provided to members who are eligible for Arizona Long Term Care System (ALTCS) services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP).
Medical supplies and DME include:

1. Surgical dressings, splints, casts, and other disposable items covered by Medicare (Title XVIII).

2. Rental or purchase of DME, including, customized equipment.

3. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

B. Requirements for specific services:

1. Incontinence Briefs

a. Incontinence briefs for members over the Age of 21 Years:

i. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:

- The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.

- The Primary Care Provider (PCP) or attending physician has issued a prescription ordering the incontinence briefs.

- Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month.

- The member obtains incontinence briefs from vendors within the Contractor's network.

- Prior authorization has been obtained if required by the Administration, Contractor, or Contractor's designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

ii. Authorized services must be for at least a 12 month period of time.

iii. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.

iv. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

v. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

vi. Any exceptions to this policy section must have the approval of the Assistant Director.

b. Incontinence briefs for members over three and under the Age of 21 Years:

Incontinence briefs are covered for members when necessary to treat a medical condition and/or for preventative purposes. For information on coverage and limitations see the *Division Medical Policy Manual Chapter 400, Section 430*.

2. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in absence of a medical condition, illness or injury.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment (DME) includes the involvement of a physical therapist in ordering and fitting customized equipment.

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment.

a. Orthotics- A device prescribed by a physical or other licensed practitioner to support a weak, injured, or deformed portion of the body.

i. Members 21 years of age and older:

Orthotics are covered within certain limitations if all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The orthotic is ordered by a Physician or Primary Care Practitioner.

ii. Members under 21 years of age:

Orthotics are covered for members under the age of 21 as outlined in the *Division Medical Policy Manual Chapter 400 Section 430-C*.

iii. Orthotics Limitations- Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

310-S OBSERVATION SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Observations services. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours (this is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight).

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, in order to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for Observation services as long as medical necessity exists. The medical record must document the basis for Observation services.

Factors That Must Be Considered by the Physician or Authorized Individual When Ordering Observation

The following factors must be considered by the physician or authorized individual when ordering Observation:

A. Severity of the signs and symptoms of the member

B. Degree of medical uncertainty that the member may experience an adverse occurrence

C. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted

D. The availability of diagnostic procedures at the time and location where the member presents

E. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission

F. Length of stay for Observation is medically necessary for the member's condition.

Required Medical Record Documentation

The following are requirements for documenting medical records:

A. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify, "Observation." Rubber-stamped orders are not acceptable.

B. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if Observation is extended.

C. Changes from "Observation to inpatient" or "inpatient to Observation" must be made per physician order.

D. Inpatient/outpatient status change must be supported by medical documentation.

Limitations

The following services are not Division-covered Observation services:

A. Substitution of Observation services for physician ordered inpatient services

B. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

C. Services provided solely for the convenience of the member or physician

D. Excessive time and/or amount of services medically required by the condition of the member

E. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.

310-V PRESCRIPTION MEDICATION/PHARMACY SERVICES

REVISION DATE: 1/24/2024, 1/10/2024, 9/30/2020, 7/3/2015, 9/15/2014
REVIEW DATE: 12/23/2022
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 CFR 431.52; 42 CFR 438.3(s); 42 USC 1396A(OO); A.R.S. § 32-1974; A.R.S. § 36-550; A.R.S. §36-551; A.R.S. § 36-2918(A)(1); A.R.S. §36-2918(A)(3)(b); A.R.S. § 36-2930.03; A.A.C. R4-23-409; R9-22-201 et seq; A.A.C. R9-22-209(C); A.A.C. R9-22-702; A.A.C. R9-22-709; A.A.C. R9-22-710(C); A.A.C. R9-22-711; A.A.C. R9-28-201 et seq; A.A.C. R9-31-201 through R9-31-216; Social Security Act Section 1927 (g) Drug Use Review; AMPM 310-M; AMPM 320-N; AMPM 320 T-1; AMPM 320 T-2; AMPM 660; AMPM Attachment 310-V (A); AMPM Attachment 310-V (B); AMPM Exhibit 300-1; AHCCCS Fee For Service Billing Manual Chapter 12; AHCCCS IHS/Tribal Provider Billing Manual Chapter 10; ACOM 111; ACOM 201; ACOM Policy 414; ACOM 432; Division Medical 310-DD; Division Medical 320-M; Division Medical 320-Q; Division Medical 510.

PURPOSE

This policy specifies the requirements for the the Division of Developmental Disabilities (Division) oversight and monitoring of the medication, Device and pharmacy coverage requirements and limitations of the Arizona Health Care Cost Containment System (AHCCCS) pharmacy benefit administered by the Administrative Services Subcontractors (AdSS) for Division Members enrolled in health plans managed by the AdSS and Members enrolled in the Tribal Health Program (THP) pharmacy benefits administered by AHCCCS Division of Fee-For-Service Management (DFSM) and it’s contracted

Pharmacy Benefits Manager (PBM).

DEFINITIONS

1. "340B Ceiling Price" means the maximum price that drug manufacturers may charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to the United States Department of Health and Human Services. The 340B Ceiling Price per unit is defined as the Average Manufacturer Price (AMP) minus the Federal Unit Rebate Amount.

2. "340B Contracted Pharmacies" means a separate pharmacy that a 340B Covered Entity contracts with to provide and dispense prescription and physician-administered drugs using medications that are subject to 340B Drug Pricing Program.

3. "340B Covered Entity" means an organization as defined by 42 United States Code Section 256b that participates in the 340B Drug Pricing Program.

4. "340B Drug Pricing Program" means the discount drug

purchasing program described in Section 256b of 42 United States Code.

5. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program.

6. "Actual Acquisition Cost" or "AAC" means the purchase price of a drug paid by a pharmacy net of all discounts, rebates, chargebacks, and other adjustments to the price of the drug, not including Professional Fees.

7. "Adverse Drug Event" or "ADE" means an injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to Medication Errors, adverse drug

reactions, allergic reactions, and overdose.

8. "AHCCCS/Division of Fee-For-Service Management" or "DFSM" means the division responsible for the clinical, administrative and claims functions of the Fee-For-Service (FFS) members.

9. "AHCCCS Drug List" means a list of Preferred Drugs in specific therapeutic categories that are Federally and State reimbursable behavioral health and physical health care medications and Medical Devices that the Division utilizes for the administration of acute and long-term care pharmacy benefits. The AHCCCS Drug List includes Preferred Drugs and was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications and is supported by current evidence-based medicine.

10. "AHCCCS Fee For Service (FFS) PA criteria effective 10/1/22" means criteria which is based on clinical appropriateness, scientific evidence, and any of the following standards of practice:

    a. FDA approved indications and limits;

b. Published practice guidelines and treatment protocols;

c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential Member outcomes;

d. Drug Facts and Comparisons;

e. American Hospital Formulary Service Drug Information;

f. United States Pharmacopeia – Drug Information;

g. DRUGDEX Information System;

h. UpToDate;

i. MicroMedex;

j. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies; or

k. Other drug reference resources.

11. "AHCCCS Pharmacy and Therapeutics Committee" or "AHCCCS P&T Committee" means the advisory committee to AHCCCS, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List. The AHCCCS Pharmacy and Therapeutics Committee (AHCCCS P&T Committee) is primarily composed of physicians, pharmacists, nurses, other health care professionals and community members.

12. "Average Manufacturer Price" or "AMP" means the average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts.

13. "Biosimilar" means a biological drug approved by the Food and Drug Administration (FDA) based on a showing that it is highly similar to an FDA-Approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

14. "Centers For Medicare and Medicaid Services" or CMS" means the Federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare

program and works in partnership with State governments to administer Medicaid.

15. "Chronic Intractable Pain" means as specified in A.R.S. § 32-3248.01, meets both of the following:
    a. The pain is excruciating, constant, incurable and of such severity that it dominates virtually every conscious moment; and
    b. The pain produces mental and physical debilitation.

16. "Dual Eligible Member" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members:
    a. A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only); or
    b. A Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

17. "Emergency Medication" means for the purposes of this policy,

emergency epinephrine and diphenhydramine.

18. "Federal Supply Schedule" or "FSS" means the collection of multiple award contracts used by Federal agencies, U.S. territories, Indian tribes, and other specified entities to purchase supplies and services from outside vendors. Federal Supply Schedule (FSS) prices for the pharmaceutical schedule are negotiated by the Veterans Affairs and are based on the prices that manufacturers charge their "most-favored" non-Federal customers under comparable terms and conditions.
19. "Federal Unit Rebate Amount" means a calculation using the drug manufacturer's pricing. The specific methodology used is determined by statute, and depends upon whether a drug is classified as:
    a. Single source ("S" drug category) or Innovator multiple source ("I" drug category);
    b. "S" or "I" Line Extension Drug;
    c. Non-innovator multiple source ("N" drug category);
    d. Clotting Factor drug (CF); or

e. Exclusively Pediatric drug (EP).

20. "First Line Drug" a generic drug or lower-cost drug.

21. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes Fraud under applicable State or Federal law.

22. "Generic Drug" means a drug that contains the same active ingredients as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic Drug substitution shall be completed in accordance with Arizona State Board of Pharmacy rules and regulations.

23. "Grandfathering of Non-Preferred Drugs" means the continued authorization of Non-Preferred Drugs for Members who are currently utilizing Non-Preferred Drugs without having completed Step Therapy of the Preferred Drugs on the AHCCCS Drug List,

as appropriate.

24. "Guest Dosing" means A mechanism for Members who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for Members who need to travel for a period of time that exceeds the amount of eligible take-home doses.

25. "Initial Prescriptions for Short Acting Opioid Medication" means a short-acting opioid medication for which the Member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the Member's PBM prescription profile.

26. "JW Modifier" means a Healthcare Common Procedure Coding System (HCPCS) Level II modifier required to be reported on a claim to report the amount of drug that is discarded and eligible for payment under the discarded drug policy.

27. "Medical Device" means per Section 201(h) of the Food, Drug,

and Cosmetic Act, a Device is: An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is:

a. Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them;

b. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals;

c. Intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals; and

d. Which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. The term "Device" does not include software

functions excluded pursuant to Section 520(o) of the Federal Food, Drug and Cosmetic Act.

28. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

29. "Naloxone" means a prescription medication that reverses the effects of an opioid overdose.

30. "Nominal Price" means a drug that is purchased for a price that is less than 10% of the AMP in the same quarter for which the AMP is computed.

31. "Non-Preferred Drug" means a medication that is not listed on the AHCCCS Drug List. Non-Preferred Drugs require Prior Authorization (PA).

32. "Non-Title XIX/XXI Member" means a Member who needs or may be at risk of needing covered health-related services but does not meet Federal and State requirements for Title XIX or Title XXI eligibility.

33. "Preferred Drug" means a medication that has been clinically

reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List as a Preferred Drug due to its proven clinical efficacy and cost effectiveness.

34. "Professional Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Professional Fee does not include any payment for the drug being dispensed.

35. "Repack" or "Repackage" means the act of taking a finished drug product or unfinished drug from the container in which it was placed in commercial distribution and placing it into a different container without manipulating, changing, or affecting the composition or formulation of the drug.

36. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

37. "Standing Order" means an AHCCCS registered prescriber's order that can be exercised by other health care workers for a Member that meets the designated criteria by the prescribing provider.

38. "Step Therapy" means the practice of initiating drug therapy for a medical condition with the most cost-effective and safe drug and stepping up through a sequence of alternative drug therapies if the preceding treatment option fails.

39. "Usual and Customary Price" or "U&C Price" means the dollar amount of a pharmacy's charge for a prescription to the general public, a special population, or an inclusive category of customers that reflects all advertised savings, discounts, special promotions, or other programs including membership-based discounts.

40. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. THE AHCCCS DRUG LIST

1. The Division shall require the AdSS to maintain its own drug list to meet the unique needs of the Members they serve. The Division shall ensure the AdSS drug list includes all the drugs listed on the AHCCCS Drug List.

2. The Division shall require the AdSS to cover all medically necessary, clinically appropriate, and cost-effective medications that are Federally and State reimbursable regardless of whether these medications are included on the AHCCCS Drug List.

3. The Division shall require the AdSS to maintain Preferred Drug lists that include every drug exactly as listed on the AHCCCS Drug List.

4. The Division shall not permit the AdSS to add other Preferred Drugs to their Preferred Drug lists in those therapeutic classes when the AHCCCS Drug List specifies a Preferred Drug in a particular therapeutic class.

5. The Division shall require the AdSS to inform their Pharmacy Benefit Managers (PBM) of the Preferred Drugs and shall require the AdSS' PBM to institute Point-of-Sale (POS) edits that communicate back to the pharmacy the Preferred Drugs of a therapeutic class whenever a claim is submitted for a Non-Preferred Drug.

6. The Division shall require the AdSS to cover the Preferred Drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS, with an effective date by the first day of the first month of the quarter following the AHCCCS P&T Committee meeting, unless otherwise communicated by AHCCCS.

7. The Division shall require AdSS to approve the Preferred Drugs listed for the therapeutic classes contained on the AHCCCS Drug List, as appropriate, before approving a Non-Preferred Drug unless:
   a. The Member has previously completed Step Therapy using the Preferred Drugs; or
   b. The Member's prescribing clinician provides documentation

supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the Member.

8. The Division shall require that the AdSS does not disadvantage one Preferred Drug over another Preferred Drug when AHCCCS has approved Preferred Drugs or supplemental rebates for a therapeutic class.

9. The Division shall not permit the AdSS to require a trial and failure of one preferred agent when there are others that are also preferred and have the same indication as part of their Prior Authorization(PA) criteria.

10. The Division shall require the AdSS to require PA for the Non-Preferred Drug when the prescribing clinician is not in agreement with transition to the Preferred Drug.

11. The Division shall not require the AdSS to provide a Notice of Adverse Benefit Determination when the prescribing clinician agrees with the change to the First Line or Preferred Drug.

12. The Division shall require the AdSS to issue a Notice of Adverse

Benefit Determination for service authorizations when a PA request for a Preferred Drug is denied or a previously approved authorization is terminated, suspended, or reduced.

13. The Division shall require the AdSS to Grandfather Members on medications that AHCCCS has communicated to the Division and AdSS as approved for Grandfathering.

14. The Division shall ensure all Federally and State reimbursable drugs that are not listed on the AHCCCS Drug List or the AdSS drug lists are available through the PA process.

15. The Division shall require the AdSS to not deny a Federally and State reimbursable medication solely due to the lack of an FDA indication. Off-Label prescribing may be clinically appropriate when evidenced by subsections (a) through (k) above.

16. The Division shall prohibit the AdSS from adding PA or Step Therapy requirements to medications listed on the AHCCCS Drug List when the List does not specify these requirements.

17. The Division shall prohibit the AdSS from denying coverage of a

medically necessary medication when the Member's primary insurer, other than Medicare Part D, refuses to approve the request and the primary insurer's grievance and appeals process has been completed.

18. The Division shall require the AdSS to evaluate the medical necessity of the submitted PA for all Federally and State reimbursable medications, including those listed and those not listed on the AHCCCS Drug List.
19. The Division shall require the AdSS to evaluate the submitted PA request on an individual basis for medications that are Non-Preferred Drugs and not listed on the AHCCCS Drug List.
20. The Division shall require the AdSS to submit requests for medication additions, deletions, or other changes to the AHCCCS Drug List to the AHCCCS P&T Committee for review no later than 60 days prior to the AHCCCS P&T Committee meeting to the AHCCCS Pharmacy Department email at: AHCCCSPharmacyDept@azahcccs.gov.
21. The Division shall require the AdSS to provide the following

information with the request for medication additions, deletions, or other changes to the AHCCCS Drug List:

a. Name of medication requested (brand name and generic name);

b. Dosage forms, strengths, and corresponding costs of the medication requested;

c. Average daily dosage;

d. FDA indication and accepted off-label use;

e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List;

f. Adverse Drug Event (ADE) reported with the medication;

g. Specific monitoring requirements and costs associated with these requirements; and

h. A clinical summary for the addition, deletion, or change request.

22. The Division shall require the AdSS to adopt the quantity limits and Step Therapy requirements exactly as they are presented on the AHCCCS Drug List for all Preferred Drugs specified on the

AHCCCS Drug List.

23. The Division shall require the AdSS to develop Step Therapy requirements for therapeutic classes when there are no Preferred Drugs identified on the AHCCCS Drug List.

24. The Division shall require the AdSS to obtain PA for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug.

25. The Division shall require the AdSS to issue a Notice of Adverse Benefit Determination for service authorizations when a PA request for quantity limits or Step Therapy is denied, or a previously approved authorization is terminated, suspended, or reduced.

B. GENERIC AND BIOSIMILAR DRUG SUBSTITUTIONS

1. The Division shall require the AdSS to utilize a mandatory Generic Drug substitution policy that requires the use of a generic equivalent drug whenever one is available, except for the following:

a. A brand name drug shall be covered when a generic equivalent is available and the AHCCCS negotiated rate for the brand name drug is equal to or less than the cost of the Generic Drug; or

b. When the cost of the Generic Drug has an overall negative financial impact to the State. The overall financial impact to the State includes consideration of the Federal and supplemental rebates.

2. The Division shall require the AdSS to require prescribing clinicians to clinically justify the use of a brand-name drug over the use of its generic equivalent through the PA process.

3. The Division shall not permit the AdSS to transition to a Biosimilar drug until AHCCCS has determined that the Biosimilar drug is overall more cost-effective to the State than the continued use of the brand name drug.

4. The Division shall require the AdSS to provide the Generic Drug substitution policy during the Operational Review.

5. The Division shall review the Generic Drug substitution policy provided by the AdSS during the Operational Review.

C. ADDITIONAL INFORMATION FOR MEDICATION COVERAGE

1. The Division shall require the AdSS to cover medications for Members transitioning to a different health plan or FFS as follows:
   a. The transferring AdSS or AHCCCS DFSM provide coverage for medically necessary, cost-effective, and Federally and State reimbursable medications until such time that the Member transitions to their new health plan or FFS Program; and
   a. The AdSS, providers, and Tribal Regional Behavioral Health Authorities (TRBHAs) are responsible for coordinating care when transferring a Member to a new health plan or FFS Program to ensure that the Member's medications are continued during the transition.

2. The Division shall require the AdSS to provide coverage for medically necessary, cost-effective, and Federally and State

reimbursable behavioral health medications provided by a Primary Care Physician (PCP) within their scope of practice which includes the monitoring and adjustments of behavioral health medications.

3. The Division shall require the AdSS to obtain PA for antipsychotic medication class based on age limits depending on the form of the medication.

4. The Division shall require the AdSS to ensure PCPs and BHMPs coordinate the Member's care and that the Member has a sufficient supply of medications to last through the date of the Member's first appointment with the PCP or BHMP when a Member is transitioning from a BHMP to a PCP or from a PCP to a BHMP.

5. The Division shall require the AdSS to allow an individual receiving Methadone or Buprenorphine administration services who is not a recipient of take-home medication to receive Guest Dosing of Methadone or Bupenorphine from the area contractor when the individual is traveling outside of home Opioid

Treatment Program (OTP) center.

6. The Division shall require the AdSS to allow a Member to be administered sufficient daily dosing from an OTP center other than their home OTP center when:
   a. A Member is unable to travel to the home OTP center, or
   b. When traveling outside of the home OTP center's area.

7. The Division shall require the AdSS to allow a Member to receive Guest Dosing from another OTP center (guest OTP center) within their Geographic Service Areas (GSA), or outside their GSA.

8. The Division shall require the AdSS to approve Guest Dosing outside the State of Arizona when the prescribing physician determines the Member's health would be endangered if travel were required back to the state of residence.

9. The Division shall require the AdSS to permit a Member to qualify for Guest Dosing when:
   a. The Member is receiving administration of Medications for Opioid Use Disorder (MOUD) services from a

SAMHSA-Certified OTP (Substance Abuse and Mental Health Services Administration);

b. The Member needs to travel outside their home OTP center area,

c. The Member is not eligible for take home medication, and

d. The home OTP center (sending OTP center) and guest OTP center have agreed to transition the Member to the guest OTP center for a scheduled period of time.

10. The Division shall require the AdSS does not charge Title XIX/XXI Members for Guest Dosing except as permitted by A.A.C. R9-22-702 and A.A.C. R9-22-711.

11. The Division shall require the AdSS does not charge Non-Title XIX/XXI eligible Members copayments for Guest Dosing.

D. OVER THE COUNTER MEDICATION

The Division shall require the AdSS to cover an over-the-counter (OTC) medication under the pharmacy benefit when it is prescribed in place

of a covered prescription medication when it is clinically appropriate, equally safe, effective, and more cost effective than the covered prescription medication.

E. PRESCRIPTION DRUG COVERAGE, BILLING LIMITATIONS, AND PRESCRIPTION DELIVERY

1. The Division shall require the AdSS to not cover a new prescription or refill prescription in excess of a 30-day supply unless:
    a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 90-day supply;
    b. The Member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 90 days; or
    c. The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.
2. The Division shall require the AdSS to provide prescription drugs for covered transplant services in accordance with AdSS Medical

Policy Manual Policy 310-DD.

3. The Division shall require the AdSS to cover the following for Members who are eligible to receive Medicare:
   a. OTC medications that are not covered as part of the Medicare Part D prescription drug program and the drug meets the requirements in Section (D) of this policy;
   b. A drug that is excluded from coverage under Medicare Part D by the Centers For Medicare and Medicaid Services (CMS) and the drug is medically necessary and Federally reimbursable; and
   c. Cost sharing for medications to treat behavioral health conditions for individuals with an SMI designation.
4. The Division shall not permit the AdSS to allow pharmacies to charge a Member the cash price for a prescription, other than an applicable copayment, when the medication is Federally and State reimbursable and the prescription is ordered by an AHCCCS registered prescribing clinician.

5. The Division shall not permit the AdSS to allow pharmacies to split-bill the cost of a prescription claim to the AdSS PBMs for Members.

6. The Division shall not permit the AdSS PBMs pharmacies to allow a Member to pay cash for a partial prescription quantity for a Federally and State reimbursable medication when the ordered drug is written by an AHCCCS registered prescribing clinician.

7. The Division shall require the AdSS to communicate to the pharmacies that they are prohibited from auto-filling prescription medications.

8. The Division shall not permit the AdSS to allow pharmacies to submit prescription claims for reimbursement in excess of the Usual and Customary Price (U&C Price) charged to the general public.

9. The Division shall require the AdSS to ensure that the sum of charges for both the product cost and dispensing fee does not exceed a pharmacy's U&C Price for the same prescription.

10. The Division shall require the AdSS to ensure that the U&C Price submitted ingredient cost is the lowest amount accepted from any Member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the Member to enroll or pay a fee to join the program.

11. The Division shall require the AdSS to ensure pharmacies that purchase drugs at a Nominal Price outside of 340B or the FSS bill their Actual Acquisition Cost (AAC) of the drug.

F. PA REQUIREMENTS FOR LONG-ACTING OPIOID MEDICATIONS

1. The Division shall require the AdSS, AdSS' PBM or AHCCCS' PBM, as applicable, to require the prescriber to obtain PA for all long-acting opioid prescription medications unless the Member's diagnosis is one the following:
   a. Active oncology diagnosis with neoplasm related pain;
   b. Hospice care; or
   c. End of life care (other than hospice).

2. The Division shall require the AdSS, AdSS' PBM or AHCCCS' PBM as applicable, to require the prescriber to obtain their approval or an exception for all long-acting opioid prescription medications.

G. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS UNDER 18 YEARS OF AGE

1. The Division shall require the AdSS to require a prescriber to limit the initial and refill prescriptions for any short-acting opioid medication for a Member under 18 years of age to no more than a 5-day supply, except as otherwise specified in Section (G) (2) below, "Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The Division shall require the AdSS abide by the following Conditions and Care Exclusions from the 5-day Supply Limitation:

   a. The initial and refill prescription 5-day supply limitation for short- acting opioid medications does not apply to prescriptions for the following conditions and care

instances:

i. Active oncology diagnosis;

ii. Hospice care;

iii. End-of-life care (other than hospice);

iv. Palliative Care;

v. Children on an opioid wean at the time of hospital discharge;

vi. Skilled nursing facility care;

vii. Traumatic injury, excluding post-surgical procedures;

viii. Chronic conditions for which the provider has received PA approval through the AdSS;

b. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, Initial Prescriptions for Short-Acting Opioid Medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

H. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS 18 YEARS OF AGE AND OLDER

1. The Division shall require the AdSS to require a prescriber to limit the initial prescription for any short-acting opioid medication for a Member 18 years of age and older to no more than a 5-day supply, except as otherwise specified in Section (H) (2) below, "Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The Division shall require the AdSS to abide by the following Conditions and Care Exclusions from the 5-day Initial Supply Limitation:

    a. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

        i. Active oncology diagnosis;

        ii. Hospice care;

        iii. Palliative Care;

iv. Skilled nursing facility care;

v. Traumatic injury, excluding post-surgical procedures;

vi. Post-surgical procedures; and

vii. The medication is for SUD treatment.

b. Initial Prescriptions for Short-Acting Opioid Medications for post-surgical procedures are limited to a supply of no more than 14 days.

I. ADDITIONAL FEDERAL OPIOID LEGISLATION (42 USC 1396A(OO)) MONITORING REQUIREMENTS

1. The Division shall require the AdSS to implement automated processes to monitor the following opioid safety edits at the POS:

a. A 5 days supply limit for opioid naïve members;

b. Quantity limits;

c. Therapeutic duplication limitations;

d. Early fill limitations;

e. Opioid naïve Members prescribed an opioid, and the Morphine Equivalent Daily Dose (MEDD) is 50 or greater;

f. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90 and the Member is not opioid naive;

g. Members with concurrent use of an opioid in conjunction with a benzodiazepine or an antipsychotic;

h. Members are prescribed an opioid after being prescribed drugs used for MOUD for an Opioid Use Disorder (OUD);

i. OUD diagnosis;

j. Antipsychotic prescribing for children;

k. Fraud, Waste, and Abuse by enrolled Members, pharmacies, and prescribing clinicians; and

l. Prospective and retrospective opioid reviews.

2. The Division shall require the AdSS to report Drug Utilization Review management activities annually to the Division.

3. The Division shall require the AdSS to allow a health care professional to write for a prescription that is more than 90 Morphine Milligram Equivalents (MME) per day if the prescription is:

   a. A continuation of a prior prescription order issued within the previous 60 days;

   b. An opioid with a maximum approved total daily dose in the labeling as approved by the U.S. Food and Drug Administration (FDA);

   c. For a Member who has an active oncology diagnosis or a traumatic injury;

   d. Receiving opioid treatment for perioperative surgical pain;

   e. For a Member who is hospitalized;

   f. For a Member who is receiving hospice care, end-of-life care, palliative care, skilled nursing facility care or treatment for burns;

   g. For a Member who is receiving MAT for a substance use

disorder; or

h. For chronic intractable pain.

J. NALOXONE

1. The Division shall require the AdSS to cover and consider Naloxone as an essential prescription medication to reduce the risk and prevent an opioid overdose death.

2. The Division shall require the AdSS to require a prescription, ordered by an AHCCCS registered provider, be on file at the pharmacy when Naloxone is dispensed to or for a specific Member.

3. The Division shall require the AdSS to adhere to the following process:

   a. Have a Standing Order written by the Director of the Arizona Department of Health Services on file at all Arizona pharmacies;

   b. Identify the following eligible candidates that may obtain

Naloxone:

i. Members who use illicit or non-prescription opioids with a history of such use;

ii. Who have a history of opioid misuse, intoxication, or a recipient of emergency medical care for acute opioid poisoning;

iii. Members who have been prescribed high dose opioid prescriptions of 90 MEDD or less if there are other risk factors;

iv. Members who have been prescribed an opioid with a known or suspected concurrent alcohol use;

v. Members who are from opioid detoxification and mandatory abstinence programs;

vi. Members who have been treated with methadone for addiction or pain;

vii. Members who have an opioid addiction and smoking or Chronic Obstructive Pulmonary Disease (COPD) or

other respiratory illness or obstruction;

viii. Members who have been prescribed opioids who also have renal, hepatic, cardiac, or HIV/AIDs (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) disease;

ix. Members who have difficulty accessing emergency services;

x. Members who have been assigned to a pharmacy or prescribing clinician;

xi. Members who voluntarily request Naloxone and are the family member or friend of a Member at risk of experiencing an opioid related overdose; and

xii. Members who voluntarily request Naloxone and are in the position to assist a Member at risk of experiencing an opioid related overdose.

4. The Division shall require the AdSS to cover:

a. Naloxone Solution plus syringes,

b. Naloxone Nasal Spray known as Narcan Nasal Spray, and

c. Refills of the above Naloxone products on an as needed basis.

5. The Division shall require the AdSS to require the pharmacy to educate every Member on the use of Naloxone by the pharmacist dispensing the medication in accordance with Arizona State Board of Pharmacy Regulations.

K. PHARMACY BENEFIT EXCLUSIONS

1. The Division shall require the AdSS to treat the following pharmacy benefits as excluded and shall not be covered:

a. Medications prescribed for the treatment of a sexual or erectile dysfunction, unless:

i. The medication is prescribed to treat a condition other than a sexual or erectile dysfunction, and

ii. The FDA has approved the medication for the specific

condition.

b. Medications that are personally dispensed by a physician, dentist, or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed;

c. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the FDA;

d. Outpatient medications for Members under the Federal Emergency Services Program, except for dialysis related medications for extended services individuals;

e. Medical Marijuana;

f. Drugs eligible for coverage under Medicare Part D for Members eligible for Medicare whether or not the Member obtains Medicare Part D coverage except for Dual Eligible Members that have creditable coverage or individuals with an SMI designation;

g. Experimental medications as specified in A.A.C. §

9-22-203;

h. Medications furnished solely for cosmetic purposes;

i. Medications used for weight loss treatment; or

j. Complementary and Alternative Medicines.

L. RETURN OF AND CREDIT FOR UNUSED MEDICATIONS

1. The Division shall require the AdSS to require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge, or death of a Member.
2. The Division shall require the AdSS to have the outpatient pharmacy issue a payment or credit reversal to the AdSS or the AdSS PBM for unused prescription medications. The pharmacy may charge a restocking fee when agreed upon with AHCCCS and the Division or AdSS.
3. The Division shall require the AdSS to require the return of unused prescription medication in accordance with Federal and

State laws.

4. The Division shall require the AdSS to maintain documentation and include the quantity of medication dispensed and utilized by the Member.

5. The Division shall require the AdSS to issue a credit to AHCCCS if the Member is enrolled in the THP, TRBHA, or FFS Program, to the Member's AdSS for Members who are not FFS when the unused medication is returned to the pharmacy for redistribution.

M. DISCARDED PHYSICIAN-ADMINISTERED MEDICATIONS

1. The Division shall allow any discarded portion of Federally and State reimbursable, physician-administered drugs that are unit-dose or unit-of-use designated products in MediSpan or First DataBank to be billed to the AdSS.

2. The Division shall require AdSS to ensure prescribers use the most cost-effective product(s) for the required dose to be

administered.

3. The Division shall require the AdSS to not allow billing from the prescriber or reimburse the prescriber for any use or discarded portion of a unit-of-use or unit dose Repackaged drugs.

4. The Division shall require the AdSS to ensure, for multidose products, prescribers only bill for the actual amount of drug that was used and the AdSS only reimburse the actual amount of used drug.

N. PRIOR AUTHORIZATION CRITERIA FOR SMOKING CESSATION AIDS

The Division shall require the AdSS to follow the AHCCCS established PA criteria for tobacco cessation aids.

O. VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO INDIVIDUALS THREE YEARS OF AGE AND OLDER

1. The Division shall require the AdSS to cover vaccines and Emergency Medication without a prescription order when

administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and A.R.S. § 32-1974.

2. The Division shall require the AdSS to ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, only administer influenza and COVID immunizations to Members who are at least three years of age through 18 years of age.

3. The Division shall require the AdSS to ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, administer AHCCCS covered immunizations to adults at least 18 years and older as specified in A.R.S. § 32-1974.

4. The Division shall require the AdSS to ensure the pharmacies providing the vaccine are an AHCCCS registered provider.

5. The Division shall require the AdSS to retain the discretion to determine the coverage of vaccine administration by

pharmacists, pharmacy interns and technicians under the supervision of a pharmacist and that coverage is limited to the AdSS network pharmacies unless otherwise directed by AHCCCS.

P. 340B COVERED ENTITIES AND CLAIM SUBMISSION

1. The Division shall require the AdSS to ensure that 340B covered entities submit the AAC of the drug for Member's POS prescription and physician-administered drug claims that are identified on the 340B pricing file, whether or not the drugs are purchased under the 340B Drug Pricing Program.

2. The Division shall require the AdSS to reimburse POS claims at the lesser of:
   a. The AAC, or
   b. The 340B Ceiling Price, and
   c. A Professional Fee (dispensing fee).

3. The Division shall require the AdSS to ensure physician administered drugs are reimbursed at the lesser of the AAC or the 340B ceiling price, and the Professional (dispensing) Fee is

not reimbursed and is not permitted when a physician administered drug is administered by the prescribing clinician.

4. The Division shall require the AdSS to not reimburse 340B Contracted Pharmacies for drugs that are purchased, dispensed, or administered as part of or subject to the 340B Drug Pricing Program.

5. The Division shall require the AdSS to comply with any changes to reimbursement methodology for 340B entities.

Q. PHARMACEUTICAL REBATES

1. The Division shall require the AdSS, including the THP PBM and AdSS' PBM, to be prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product.

2. The Division shall require the AdSS or its PBM's consider outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, to be exempt

from such rebate agreements if they have an existing rebate agreement with a manufacturer.

R. INFORMED CONSENT

1. The Division shall require the AdSS to ensure the prescriber obtains informed consent from the Responsible Person for each psychotropic medication prescribed.

2. The Division shall require the AdSS to ensure that prescribers are documenting the essential elements for obtaining informed consent in the comprehensive clinical record, utilizing AMPM Attachment 310-V (A).

S. YOUTH ASSENT

1. The Division shall require the AdSS to ensure prescribers educate youth under the age of 18 on options, are allowed to provide input, and are encouraged to assent to medications

being prescribed.

2. The Division shall require the AdSS to ensure prescribers discuss this information with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth.

3. The Division shall require the AdSS to ensure prescribers share information with Members who are under the age of 18 that is consistent with the information shared in obtaining informed consent from adults.

4. The Division shall require the AdSS to ensure the prescribers obtain informed consent for a minor through the minor's authorized Responsible Person unless the minor is emancipated.

5. The Division shall require the AdSS to ensure prescribers discuss the youth can give consent for medications when they turn 18.

6. The Division shall require the AdSS to begin the discussion about consent for medication no later than age 17½ years old, especially for youth who are not in the custody of their parents.

7. The Division shall require the AdSS to ensure prescribers address

the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements, and other health parameters.

8. The Division shall require the AdSS to ensure the prescribers document evidence of the youth's consent to continue medications after their 18th birthday through use of AMPM Attachment 310-V (A).

T. PRESCRIPTION DRUG COUNSELING

The Division shall require the AdSS to communicate to the pharmacy network that pharmacists, and graduate and non-graduate pharmacy interns, under the supervision of a pharmacist are to provide counseling on prescription drugs, prescribed and dispensed to AHCCCS members, in accordance with the Arizona State Board of Pharmacy A.A.C. 4-23-402.

U. DIVISION OVERSIGHT AND MONITORING

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

1. A controlled substance is defined in A.R.S. § 32-3248.01. For opioid prescribing guidelines refer to the Arizona Opioid Epidemic Act.
2. The Division shall require the AdSS to cover medically necessary,

cost-effective and federally and State reimbursable medications and devices for Members as prescribed or administered by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner with prescriptive authority in the State of Arizona and dispensed by an AHCCCS registered licensed pharmacy pursuant to 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2, and for persons with a SMI designation, pursuant to A.R.S. § 36-550.

3. Generic and Biosimilar substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.

4. Arizona 340B entity hospitals, and outpatient facilities owned and operated by a 340B entity hospital, are not exempt from the reimbursement methodology listed in Section (P) (2).

5. Effective with a future date to be determined, 340B hospitals and outpatient facilities, owned and operated by a 340B hospital, shall be required to submit claims at the entity's AAC.

6. The provider shall use the most cost-effective product(s) for the

required dose to be administered. For example, if the dose to be administered is 12mg and the product is available in a 10mg and 50mg vial, the provider shall use two - 10mg vials to obtain the 12mg dose. The 12mg dose shall be billed as the administered dose and 8mg shall be billed as discarded waste using the JW modifier.

7. Effective 01/01/22 repackaged medications are not Federally and State reimbursable.

8. Mental Health Block Grant (MHBG) provisions shall apply to Children with Serious Emotional Disturbance (SED), Individuals in First Episode Psychosis (FEP), and Adults with SMI designation. For individuals with a Substance Use Disorder (SUD), Substance Abuse Block Grant (SABG) provisions shall apply.

9. The AHCCCS Pharmacy and Therapeutics (P&T) Committee is responsible for developing, managing, and updating the AHCCCS Drug List to assist providers in selecting clinically appropriate

and cost-effective drugs or devices for Members.

10. The AHCCCS Drug List is not an all-inclusive list of medications for Members.

11. The AHCCCS P&T Committee shall make recommendations to the AdSS on the Grandfathering status of each Non-Preferred Drug for each therapeutic class reviewed by the committee.

12. The AHCCCS Drug List specifies which medications require PA prior to dispensing the medication.

13. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated that typically require the use of a more cost effective drug that is safe and effective to be used prior to approval of a more costly medication.

14. Guest Dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support.

15. Pharmacies, at their discretion, shall deliver or mail prescription medications to a Member or to an AdSS registered provider's

office for a specific Member.

The Sending OTP Center

1. The Sending OTP Center shall forward information to the Receiving OTP Center prior to the Member's arrival, information shall include:
    a. A valid release of information signed by the Member;
    b. Current medications;
    c. Date and amount of last dose administered or dispensed;
    d. Physician order for Guest Dosing, including first and last dates of Guest Dosing;
    e. Description of clinical stability including recent alcohol or illicit drug Abuse; and
    f. Any other pertinent information.
2. The Sending OTP Center shall provide a copy of the information to the Member in a sealed, signed envelope for the Member to present to the Receiving OTP Center.
3. The Sending OTP Center shall submit notification to the AdSS of

enrollment of the Guest Dosing arrangement.

4. The Sending OTP Center shall accept the Member upon return from the Receiving OTP Center unless other arrangements have been made.

The Guest OTP Center

1. The Guest OTP Center shall:
    a. Respond to the Sending OTP Center in a timely fashion, verifying receipt of information and acceptance of the Member for guest medication as quickly as possible;
    b. Provide the same dosage that the Member is receiving at the Member's Sending OTP Center, and change only after consultation with Sending OTP Center;
    c. Bill the Member's Contractor of enrollment for reimbursement utilizing the appropriate coding and modifier;
    d. Provide address of Guest OTP Center and dispensing hours;

e. Determine appropriateness for dosing prior to administering a dose to the Member. The Guest OTP Center has the right to deny medication to a Member if they present inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with other Members;

f. Communicate any concerns about a guest-dosing the Member to the Sending OTP Center including termination of guest-dosing if indicated; and

g. Communicate the last dose date and amount back to the Sending OTP Center.

Signature of Chief Medical Officer: Anthony Dekker (Jan 18, 2024 17:39 MST)
Anthony Dekker, D.O.

310-X REHABILITATIVE THERAPY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational, and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.

310–Y RESPIRATORY THERAPY

EFFECTIVE DATE: March 3, 2017
REFERENCES: A.R.S. § 32-3501

The Division of Developmental Disabilities (Division) covers respiratory therapy treatment service for members eligible for ALTCS, when ordered by a primary care provider, to restore, maintain, or improve respiratory functioning.

Services include:

A. Administering pharmacological, diagnostic, and therapeutic agents related to respiratory and inhalation care procedures

B. Observing and monitoring signs and symptoms

C. General behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response(s) exhibit abnormal characteristics

D. Implementing appropriate reporting referral

E. Implementing respiratory care protocols or changes in treatment based on observed abnormalities.

The Division covers medically necessary respiratory therapy services for all members eligible for ALTCS on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. § 32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to Division members outside the State of Arizona must meet the applicable state and/or federal requirements.

310-BB TRANSPORTATION FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

REVISION DATE: 02/22/2023, 10/1/2021, 11/17/2017, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211, A.A.C. R9-22-211,AMPM 310, AMPM 310-BB, AMPM 320-I, AMPM 700

PURPOSE

This policy describes covered transportation services for members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Alternative Destination Partner" means an Arizona Health Care Cost Containment System (AHCCCS) registered provider, such as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC), primary care provider doctor, specialist, behavioral health center or urgent care clinic.

2. "Certificate of Necessity (CON)" means regulations that require healthcare providers to get special permission from the government before adding or expanding healthcare services or

facilities.

3. "Emergency Transportation" means ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
   a. Placing the member's health in serious jeopardy, or
   b. Serious impairment of bodily functions, or
   c. Serious dysfunction of any bodily organ or part, or
   d. Serious physical harm to self or another individual.

4. "Emergency Triage, Treat, and Transport", "ET3" means a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation providers to address a member's health care needs following a

9-1-1 call. ET3 permits Emergency Transportation providers to transport a member to the nearest appropriate AHCCCS-registered facility, and to initiate and facilitate a members' receipt of medically necessary covered service(s) at the scene of a 9-1-1 response either in-person on the scene or via telehealth.

5. "Maternal Transport Program (MTP)"/" Newborn Intensive Care Program (NICP)" means programs that are administered by the ADHS that provide special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center.

POLICY

A. EMERGENCY TRANSPORTATION

1. The Division shall cover Emergency Transportation in emergent situations in which specially staffed and equipped ambulance transportation is required to safely manage the member's condition.

2. The Division shall cover basic life support, advanced life support, and air ambulance services when medically necessary.
3. The Division shall cover emergency transportation for an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
    a. Placing the member's health in serious jeopardy,
    b. Serious impairment of bodily functions,
    c. Serious dysfunction of any bodily organ or part, or
    d. Serious physical harm to another person (for behavioral health conditions).
4. The Division shall not require prior authorization for emergency transportation.
5. The Division shall cover Emergency Transportation that includes the transportation of a member to a higher level of care for immediate medically necessary treatment, including when occurring after stabilization at an emergency facility.

6. The Division shall cover emergency medical transportation to the nearest appropriate AHCCCS-registered facility capable of meeting the member's physical and behavioral health needs.

B. AIR AMBULANCE

1. The Division shall cover air ambulance services under the following conditions:
   a. The air ambulance transport is initiated at the request of:
      i. Emergency response unit,
      ii. Law enforcement official,
      iii. Clinic or hospital medical staff member, or
      iv. Physician or practitioner.
   b. The point of pickup is:
      i. Inaccessible by ground ambulance,
      ii. There is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance will not suffice, or

iii. The medical condition of the member requires immediate intervention of emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.

2. The Division shall ensure that air ambulance companies are licensed by the Arizona Department of Health Services (ADHS) and registered as a provider with AHCCCS.

C. EMERGENCY TRIAGE, TREAT AND TRANSPORT PROGRAM (ET3)

1. The Division shall cover the Emergency Triage, Treat, and Transport Program (ET3) when an Emergency Transportation provider responds to a "9-1-1", fire, police, or other locally established system for emergency calls.

2. The Division shall require the Emergency Transportation provider be AHCCCS-registered and have a Certificate of Necessity (CON) from ADHS; or are tribal providers who have a signed AHCCCS attestation of CON equivalency in order to transport a member to an appropriate AHCCCS-registered provider or provide

treatment to the member on the scene.

3. The Division shall cover transportation to an Alternative Destination Partner when the emergency response team's field evaluation of the member shows the services are medically necessary but not emergent, when the following conditions are met:

   a. Transport to an Alternative Destination Partner will meet the member's level of care more appropriately than transport to an emergency department;

   b. The appropriate AHCCCS-registered provider is within or near the responding Emergency Transportation provider's services area;

   c. The Emergency Transportation provider has a pre-established arrangement with the AHCCCS-registered provider located within their region; and

   d. The Emergency Transportation provider has knowledge of the AHCCCS-registered provider's:

i. Hours of operation;

ii. Clinical Staff available;

iii. Services provided; and

iv. Ability to arrange transportation for the member to return home, as needed.

4. The Division shall cover emergency treatment on the scene when:

a. The emergency response team's evaluation of the member shows that services are medically necessary but not emergent;

b. The Emergency Transportation provider treats the member in accordance with the provider's scope of practice and their emergency transport service's medical direction, including the use of telemedicine when medically indicated.

D. EMERGENCY TRANSPORTATION PROVIDER REQUIREMENTS FOR EMERGENCY TRANSPORTATION SERVICES PROVIDED TO MEMBERS LIVING ON TRIBAL LANDS

1. The Division shall ensure that in addition to other requirements specified in this policy, Emergency Transportation providers rendering services on tribal lands meet the following requirements:

   a. Tribal emergency transportation providers shall be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and shall be registered as an AHCCCS provider.

   b. If a non-tribal emergency transportation provider renders services under a contract with a Tribe, either on-reservation or to and from an off-reservation location, the provider shall be State licensed and certified and shall be registered as an AHCCCS provider.

   c. Non-tribal emergency transportation providers not under contract with a Tribe shall meet requirements specified in this Policy for emergency transport providers.

E. MEDICALLY NECESSARY NON-EMERGENCY TRANSPORTATION FOR MEDICAL AND BEHAVIORAL HEALTH SERVICES

1. The Division shall cover medically necessary, non-Emergency Transportation when furnished by non-Emergency Transportation providers to transport the member to and from a covered physical or behavioral service. Such transportation services may also be provided by Emergency Transportation providers after assessment by the Emergency Transportation team or paramedic team that the team determines the member's condition requires medically necessary transportation. Medically necessary non-emergency transportation is also referred to as Non-Emergency Medical Transportation (NEMT).

2. The Division shall cover NEMT services under the following conditions:

   a. The physical or behavioral health service for which the transportation is needed, is a service covered by the Division;

   b. The member is not able to provide, secure, or pay for their

own transportation, and free transportation is not available; and

c. The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.

3. The Division shall also cover NEMT services to transport a member to obtain their Medicare Part D covered prescriptions.

4. The Division shall cover medically necessary NEMT services furnished by all AHCCCS-registered providers who offer transportation for members traveling to a pharmacy. For those members living in Maricopa and Pinal counties, the travel mileage to a pharmacy is limited to 15 miles. Mileage is calculated from the pick-up location to the drop off location, one direction. NEMT trips for members traveling to Multi-Specialty Integrated Clinics (MSIC) or IHS/638 facilities are exempt from this limitation.

5. The Division shall cover non-Emergency Transportation of a family member or caregiver without the presence of the member

when provided for the purpose of carrying out medically necessary services identified in the member's service/treatment plan.

6. The Division shall cover medically necessary non-Emergency Transportation provided by non-ambulance providers when:
   a. The member must not require medical care enroute;
   b. Passenger occupancy must not exceed the manufacturer's specified seating occupancy;
   c. Members, companions, and other passengers must follow state laws regarding passenger restraints for adults and children;
      i. Vehicle must be driven by a licensed driver, following applicable State laws;
      ii. Vehicles must be insured;
      iii. Vehicles must be in good working order;
      iv. Members, companions, and other passengers must be transported inside the vehicle; and
      v. School-based providers should follow the

school-based policies in effect.

7. The Division may cover the cost of non-Emergency Transportation, if medically necessary, provided by a non-ambulance air or equine NEMT provider only when all of the following conditions are met:
   a. The service is exclusively used to transport the member to ground accessible transportation;
   b. The member's point of pick-up or return is inaccessible by ground transport; and
   c. Ground transport is not accessible because of the nature and extent of the surrounding rural or tribal terrain.

8. The Division shall cover non-Emergency Transportation when medically necessary and furnished by ambulance providers when the following conditions are met:
   a. Other methods of transportation are contraindicated, this must be documented;
   b. The medical condition (regardless of bed confinement) of

the member requires the medical treatment be provided by qualified staff in an ambulance;

c. For hospitalized members only:

i. The Division shall cover round trip air or ground transportation services if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic or therapeutic services.

d. The Division shall cover the cost of the transportation if the services are not available in the hospital in which the member is hospitalized.

9. The Division shall ensure public transportation is offered as an option to a member when it is available within the service area and NEMT services are requested and is limited to AHCCCS approved services. The following shall be considered when offering public transportation:

a. Location of the member to a transportation stop;

b. Location of the Provider and/or AHCCCS approved services to a transportation stop;

c. Coordination of the member's appointment with the public transportation schedule;

d. Ability of the member to travel alone on public transportation; or

e. Member preference.

F. MATERNAL AND NEWBORN TRANSPORTATION

1. The Division shall cover medically necessary maternal and newborn transportation through the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP).

Signature of Chief Medical Officer: Anthony Dekker (Feb 14, 2023 15:08 MST)
Anthony Dekker, D.O.

310-DD COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS

REVISION DATE: 4/26/2023, 3/1/2023, 5/18/2022, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §36-2907, 2939; A.A.C. R9-22-202, 203, 28-201, 42 CFR 438.208, AHCCCS Medical Policy Manual Chapter 300 Policy 310-DD

PURPOSE

This policy outlines the coverage for transplants, related services, and immunosuppressant medications.

DEFINITIONS

1. "Behavioral Health Professional" or BHP" means
    a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
    b. A psychiatrist as defined in A.R.S. §36-501,

c. A psychologist as defined in A.R.S. §32-2061,

d. A physician,

e. A behavior analyst as defined in A.R.S. §32-2091,

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

g. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services

2. "Disability" means a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

3. "Early and Periodic Screening, Diagnostic, and Treatment" or EPSDT" is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing

these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. “Foundation for the Accreditation of Cellular Therapy” or FACT” is a non-profit corporation co-founded by the International Society for Cellular Therapy (ISCT) and the American Society of Blood and Marrow Transplantation (ASBMT) for the purposes of

voluntary inspection and accreditation in the field of cellular therapy.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
6. "Organ Procurement and Transplantation Network" or "OPTN" is a public-private partnership operated through the United States Department of Health and Human Services and established through the National Organ Transplant Act (NOTA). The OPTN policies govern operation of all Member transplant hospitals, Organ Procurement Organizations (OPOs) and histocompatibility labs in the United States.
7. "Standard of Care" means a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community.
8. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for

medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

9. "United Network for Organ Sharing" or UNOS" means a Private, non-profit organization that manages the nations' organ transplant system under contract with Organ Procurement and Transplantation Network , including managing the national transplant Waiting List and maintaining the database that contains all organ transplant data for every transplant event that occurs in the United States.

10. "Waiting List" as defined by OPTN, is a computerized list of candidates who are waiting to be matched with specific deceased donor organs for transplant.

POLICY

A. GENERAL INFORMATION

1. The Division of Developmental Disabilities (Division) shall follow all Federal, State and Arizona Health Care Cost Containment System (AHCCCS) requirements for coverage of transplants, related services, and immunosuppressant medications.

2. The Division shall delegate the responsibility of implementing this policy to the Administrative Services Subcontractors (AdSS) for Members enrolled in a subcontracted health plan.

3. The Division shall coordinate physical and behavioral health services for Members enrolled in the Tribal Health Program (THP), while the provision and administration of organ transplant benefits will be completed by AHCCCS Department of Fee for Service Management (DFSM).

B. COVERED TRANSPLANTS

1. The Division shall cover the following transplant types for Members aged 21 and older:

   a. Heart;

   b. Single lung and double lung ;

   c. Heart-Lung;

   d. Liver

   e. Cadaveric kidney and living donor kidney;

   f. Simultaneous liver and kidney;

   g. Simultaneous pancreas and kidney;

   h. Pancreas after kidney; and

i. Hematopoietic Stem Cell Transplants:

i. Allogeneic related,

ii. Allogeneic unrelated,

iii. Autologous, and

iv. Tandem Hematopoietic Stem Cell Transplant.

2. The Division shall cover all non-experimental transplants for Members under the age of 21 under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program that are medically necessary to correct or ameliorate defects, illnesses, and physical conditions. Transplants for EPSDT Members are covered when medically necessary irrespective of whether the particular non-experimental transplant is specified as covered in AMPM 310-DD.

3. The Division shall ensure that transplants are medically necessary, non-experimental, and federally reimbursable, state reimbursable, and fall within the medical Standard of Care for coverage.

4. The Division shall use national standards for transplantation which include policy for:

a. Organ Procurement Transplant Network,

b. Centers for Medicare and Medicaid Services (CMS),

c. United Network for Organ Sharing, and

d. Foundation for the Accreditation of Cellular Therapy.

5. The Division shall cover Circulatory Assist Devices (CADs), including Left Ventricular Assist Devices (LVADs) services for destination therapy and as a bridge to transplant when medically necessary and non-experimental.

6. The Division shall cover corneal transplants and bone grafts when medically necessary, cost effective and non-experimental as specified in AMPM Exhibit 300-1 and AMPM Policy 820.

7. The Division Medical Director shall:

a. Complete a Second Level Review of all denials for transplant services and transplant related immunosuppressant medications for Members,

b. Have the final authority to approve or deny transplant services, and

c. Consult with the AHCCCS Medical Director for THP or the assigned subcontracted health plan's Medical Director

when there are questions regarding the transplant services.

C. COVERED TRANSPLANT SERVICES

1. The Division shall cover the following services, as required by the specific type of transplant:
   a. Inpatient or outpatient pre-transplant evaluation , which includes, but is not limited to, the following:
      i. Physical examination,
      ii. Psychological evaluation,
      iii. Laboratory studies,
      iv. Radiology and diagnostic imaging or procedures, and
      v. Biopsies.
   b. Donor search, Human Leukocyte Antigen (HLA) typing, and harvest as necessary for hematopoietic transplants;
   c. Pre-transplant dental evaluation and treatment as described in AMPM Policy 310-D1 under Exception for Transplant Cases;
   d. Transplantation;

e. Inpatient or outpatient post-transplant care, which may include the following:

i. Laboratory studies,

ii. Radiology and diagnostic imaging or procedures,

iii. Biopsies,

iv. Home health,

v. Skilled nursing facility services,

vi. All related transplant medications, including transplant related immunosuppressant medications, as referenced in Division Medical Manual Policy 310-V, and

vii. Transportation, and room and board for the transplant candidate, donor and, if needed, one adult caregiver as identified by the transplant facility.

1) Coverage is limited to medical treatment transportation, to and from the facility, during the time it is necessary for the Member to remain in close proximity to the transplant center.

2) Coverage includes the periods of evaluation, on-going testing, transplantation, and post-transplant care by the transplant center.

2. The Division shall ensure the Living Donor Coverage is limited to the following when provided in the United States:

a. Evaluation and testing for suitability;

b. Solid organ or hematopoietic stem cell procurement, processing, and storage; and

c. Transportation and lodging when it is necessary for:

i. The potential donor to travel for testing to determine if they are a match, and

ii. Donating either stem cells or organs.

D. CONDITIONS FOR TRANSPLANTATION

1. The Division through oversight of the AdSS shall ensure the following conditions are met for transplantation:

a. Transplant candidates meet the criteria to be added to the Waiting List.

b. Medical comorbidities are assessed through history and physical with a plan developed for appropriate care and ensure the following:

   i. Changes in medical conditions shall be assessed for the impact upon transplant candidacy.

   ii. All transplant candidates shall undergo routine age-condition appropriate screening for disease.

c. Identified indolent or chronic infections have a plan of containment in accordance with an infectious disease specialist's recommendation.

d. Members with identified neoplasms are assessed in accordance with an oncologist's recommendations.

e. Psychosocial environment is assessed, and appropriate plans are generated to mitigate issues of adherence.

f. For Members with prior adherence issues, plans with a BHP are developed.

g. The Division shall ensure that Members with substance use disorder(s) have:

i. Plans for treatment before and after the organ replacement; and

ii. Consultation with a BHP who will work as a part of the treatment team to support the Member needs and maintain wellness and recovery oriented treatment, services and supports.

E. TRANSPLANT SERVICES AND SETTINGS

1. The Division through oversight of the AdSS shall ensure solid organ transplant services are provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers as specified in 42 CFR Part 482.
2. The Division through oversight of the AdSS shall ensure hematopoietic stem cell transplant services are provided in a facility that has achieved FACT accreditation. The facility shall meet the Medicare conditions for participation and any additional federal requirement for transplant facilities.

3. The Division through oversight of the AdSS shall ensure reimbursement is only available for transplant centers that meet the above requirements.

F. ADDITIONAL REQUIREMENTS

1. The Division shall ensure the AdSS covers out-of-network solid organ or hematopoietic stem cell transplants that meet the following requirements:
   a. Services are covered for Members who have current medical requirements that cannot be met by an AHCCCS contracted transplant center.
   b. Medical requirements for an out-of-network transplant request are clearly documented, specifying the level of technical expertise or program coverage that is not provided at an AHCCCS contracted facility.
   c. Review the quality and outcome data published for the out-of-network facility.
   d. The Division shall ensure the AdSS cover solid organ living donor-related costs for pediatric kidney and liver transplants and adult kidney transplants.

2. The Division shall consider living donor transplants on a case-by-case basis for solid organs other than pediatric and adult kidney and pediatric liver when medically necessary and cost effective.
    a. Payment is limited for solid organ living donors other than pediatric and adult kidney and pediatric liver to the surgical procedure and follow-up post-op care provided to the donor through post-op day three.
    b. For any additional charges, the living donor shall accept the terms of financial responsibility for the charges associated with the transplant that are in excess of the AHCCCS Specialty Contract for Transplantation Services.
3. The Division shall provide limited coverage for medically necessary and non-experimental services following the discharge from the acute care hospital, if a Division Member receives a transplant that is not covered by AHCCCS guidelines.
    a. Excluded services:
        i. Evaluations and treatments to prepare for transplant candidacy,

ii. The actual transplant procedure and accompanying hospitalization, or

iii. Organ or tissue procurement.

b. Covered services include:

i. Transitional living arrangements appropriately ordered for post-transplant care when the Member does not live in close proximity to the transplant center,

ii. Essential laboratory and radiology procedures,

iii. Therapies that are medically necessary post-transplant,

iv. Immunosuppressant medications, and

v. Transportation that is medically necessary post-transplant.

4. The Division shall utilize the AHCCCS Specialty Contract for Transplantation Services for second covered organ transplant performed during the follow-up care periods of the first transplant.

5. The Division shall utilize the AHCCCS Reinsurance Processing Manual for transplantation reinsurance standards.
6. The Division shall utilize the AHCCCS Specialty Contract for Transplantation Services for detailed information regarding transplant coverage and payment for transplant services and transplant related services.

G. TRANSPLANT CARE COORDINATION

1. The Division's Transplant Coordinator shall coordinate with the AdSS Transplant Coordinator or the AHCCCS Transplant Coordinator at least quarterly and on an ad hoc basis to ensure Member's health services needs are being met and to ensure continuity of care.
2. The Division shall ensure on a quarterly basis, the subcontracted health plans submit Division specific AHCCCS Transplant Logs for review and tracking.
3. The Division shall ensure Members receiving care through the Tribal Health Program who are being considered for transplant services, will coordinate with the Transplant Coordinator to ensure continuity of care for the Member is maintained.

4. The Division Transplant Coordinator shall notify the Division Support Coordinator regarding the Member's transplant status. The Division Support Coordinator will work with the planning team, the Division Transplant Coordinator, and other adjunct services or support representatives and the Member to identify and address needs, modify the planning document to support the delivery of services and support as needed.

H. ORGAN TRANSPLANT ELIGIBILITY

1. The Division shall not, solely on the basis of a Member's Disability, do any of the following:
   a. Determine that the Member is ineligible to receive an organ transplant
   b. Deny the Member's medical or other services related to an organ transplant, including:
      i. Evaluation,
      ii. Surgery,
      iii. Counseling, and
      iv. Postoperative treatment.

c. Refuse to refer the Member to a transplant hospital or other related specialist for evaluation or receipt of an organ transplant.

d. Refuse to place the individual on an organ transplant Waiting List or place the Member at a position lower in priority on the list than the position the Member would be placed if not for the Member's Disability.

e. Decline insurance coverage for the Member for any procedure associated with the receipt of an organ transplant or related services associated with the receipt of an organ transplant or for related services if the procedure or services would be covered under such insurance for the Member if not for the Member's Disability.

2. The Division shall not consider a Member's inability to independently comply with posttransplant medical requirements as medically significant if the Member has a known Disability and the necessary support system to assist the Member in reasonably complying with the requirements.

I. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 10:21 PDT)
Anthony Dekker, D.O.

310-FF MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

REVISION DATE: 1/3/2024, 09/06/2023, 9/30/2020
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.54; 42 CFR 455.2; 42 USC 1396A(OO); 21 U.S.C § 802(6); A.A.C. R9-34-302; A.A.C. R9-43-202; A.A.C. Title 9, Chapter 34, Articles 2 and 3; AMPM 310-FF; AMPM 310-V; AMPM 910; AMPM 1024; ACOM 103.

PURPOSE

This policy sets forth the requirements for monitoring controlled and non-controlled medication use and the requirements to ensure Members receive clinically appropriate prescriptions.

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AdSS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Division Program.

2. "Controlled Substance" means drugs and other substances that are defined as Controlled Substances under 21 U.S.C § 802(6).

3. "CSPMP" means the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program.

4. "Drug Diversion" means redirection of prescription drugs for illicit purposes.

5. "Emergencies" means medical services provided for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

    a. Placing the Member's health in serious jeopardy;

    b. Serious impairment to bodily functions;

    c. Serious dysfunction of any bodily organ or part;

d. The medication is out-of-stock at the Exclusive Pharmacy; or

e. The Exclusive Pharmacy is closed.

6. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the Administrative Delegated Subcontractor Services (AdSS) to provide all medically necessary, federally reimbursable pharmaceuticals to the Member.

7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable State or Federal law.

8. "Intervention" means for the purpose of this policy, the requirements to ensure members receive clinically appropriate prescriptions.

9. "Member" means the same as "Client" as defined in A.R.S. §

36-551.

10. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. MONITORING REQUIREMENTS

1. The Division shall oversee and monitor controlled and non-controlled medications on an ongoing basis at quarterly meetings with reporting at the Division's Pharmacy and Therapeutics subcommittee meeting, Quality Management and Performance Improvement and Medical Management meetings.
2. The Division shall monitor the evaluation of prescription use by Members, prescribing patterns by clinicians and dispensing by pharmacies.
3. The Division shall use drug utilization data to identify and screen high-risk Members and providers who may facilitate Drug Diversion.

4. The Division shall identify monitoring requirements that determine potential misuse of the drugs used in the following therapeutic classes:
    a. Atypical Antipsychotics,
    b. Benzodiazepines,
    c. Hypnotics,
    d. Muscle Relaxants,
    e. Opioids, and
    f. Stimulants.

5. The Division shall use the following resources, when available, for their monitoring activities:
    a. Prescription claims data;
    b. Controlled Substance Prescription Monitoring Program (CSPMP);
    c. TRBHA prescription claims data; and
    d. Pertinent data used for monitoring controlled and non-controlled medication utilization.

6. The Division shall monitor the prescription encounter data quarterly to identify:
    a. Medications filled prior to the calculated days supply,
    b. Number of prescribing clinicians,
    c. Number of different pharmacies used by the Member, and
    d. Other potential indicators of medication misuse.

B. INTERVENTION REQUIREMENTS

1. The Division shall require the AdSS to implement the following required Interventions to ensure Members receive the appropriate medication, dosage, quantity, and frequency:
    a. Provider education,
    b. Point-of-Sale (POS) safety edits and quantity limits,
    c. Care management,
    d. Assignment by the AdSS of Members who meet either of the following evaluation parameters listed below to an Exclusive Pharmacy, exclusive provider or both for up to a 12-month period:

i. A Member using the following in a three-month time period:

a) Greater than four prescribers, and

b) Greater than four different Abuse potential drugs, and

c) Four Pharmacies; or

d) The Member has received 12 or more prescriptions of the medications listed in the Monitoring Requirements section in the past 3 months.

ii. A Member has presented a forged or altered prescription to the pharmacy.

2. The Division shall permit the AdSS to implement additional interventions and more restrictive parameters for referral to, or coordination of care with behavioral health service providers or other appropriate specialists when the AdSS deems it necessary or beneficial to their Members.

3. The Division shall require the AdSS to provide a written notice

detailing the factual and legal basis for the restriction, to any Member who has been assigned to an exclusive provider or pharmacy or both for up to 12 months utilizing AMPM 310-FF Attachment A.

4. The Division shall ensure the AdSS treats this restriction as an "action" pursuant to A.A.C. R9-43-202 and A.A.C. R9-34-302.

5. The Division shall require the AdSS to provide written notice that informs the Member of the opportunity to file an appeal to the restriction and the timeframes and process for doing so as described in A.A.C. Title 9, Chapter 34, Articles 2 and 3.

6. The Division shall ensure that the AdSS shall not implement the restriction before providing the Member written notice of the restriction and opportunity for an appeal or State fair hearing.

7. The Division shall require that the AdSS not impose a restriction if the Member has filed an appeal, until:
   a. The Medical Director of the AdSS' decision has affirmed the restriction,

b. The Member has voluntarily withdrawn the appeal or request for hearing, or

c. The Member fails to file an appeal or request for hearing no later than 30 calendar days from the date of the notice.

8. The Division shall require the AdSS to review the Member's prescription and other utilization data to determine whether the Interventions will be continued or discontinued, at the end of the designated time period which is no longer than every 12 months.

9. The Division shall require AdSS to notify the Member in writing of the decision to continue or discontinue the assignment of the pharmacy or provider.

10. The Division shall require the AdSS to utilize AMPM 310-FF Attachment A to include instructions for the appeals or fair hearing process to the Member if the decision is to continue the assignment.

11. The Division shall not require the AdSS to apply the Intervention of assigning an Exclusive Pharmacy or provider to emergency

services furnished to the Member.

12. The Division shall require the AdSS to ensure that the Member has reasonable access to services covered by the Division, taking into account the geographic location and reasonable travel time.
13. The Division shall require the AdSS to provide specific instructions to the Member, the assigned Exclusive Pharmacy or exclusive provider, and their Pharmacy Benefit Manager, on how to address Emergencies.
14. The Division shall allow the AdSS to assign Members who meet any of the parameters in Section (B)(15) to a single prescriber in addition to the assignment to an Exclusive Pharmacy.
15. The Division shall not allow the AdSS to subject Members with one or more of the following conditions to the Intervention requirements described in Section (B)(1):
    a. Treatment for an active oncology diagnosis,
    b. Receiving hospice care, or
    c. Residing in a skilled nursing facility or intermediate care facility.

C. REPORTING REQUIREMENTS

1. The Division shall require the AdSS to refer any identified cases of Member deaths due to medication poisoning, overdose or toxic substances and an incident must be filed with the Division's Quality Management staff for research and review.

2. The Division shall require the AdSS to report all suspected Fraud, Waste, and Abuse to the appropriate entity, and copy the Division as specified in ACOM 103.

3. The Division's Health Plan Oversight Committee shall review all Fraud, Waste and Abuse reports.

4. The Division shall require the AdSS report the number of Members on that day that are assigned to an Exclusive Pharmacy or single prescriber, or both, due to excessive use of prescription medications, controlled and non-controlled medications , utilizing AMPM Attachment 1024-A.

5. The Division shall require the AdSS to report to the Division any material changes when the AdSS has additional changes and

implements additional Interventions and more restrictive parameters as noted in this policy.

D. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
    a. Annual Operational Review of each AdSS,
    b. Review and analyze deliverable reports submitted by the AdSS, and
    c. Conduct oversight meetings with the AdSS for the purpose of:
        i. Reviewing compliance,
        ii. Addressing concerns with access to care or other quality of care concerns,
        iii. Discussing systemic issues, and
        iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Dec 29, 2023 10:29 MST)

Anthony Dekker, D.O.

310-GG NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTERAL NUTRITION

REVISION DATE: 2/7/2024
REVIEW DATE: 7/25/2023
EFFECTIVE DATE: 06/07/2023
REFERENCES: A.R.S. § 20-2327, AMPM 310-GG, AMPM Policy 430, AMPM 520, AMPM Policy 820

PURPOSE

This policy describes coverage of and requirements for nutritional therapy, metabolic foods and Total Parenteral Nutrition (TPN) for Division of Developmental Disability (DDD) Members, 21 years of age and older, who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Enteral Nutrition" means liquid nourishment provided directly to the digestive tract of a Member who cannot ingest an appropriate amount of calories to maintain an acceptable

nutritional status. Enteral nutrition is commonly provided by Jejunostomy Tube (J-Tube), Gastrostomy Tube (G-Tube) or Nasogastric (N/G Tube).

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Metabolic Medical Food Formulas" or "Medical Foods" means nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing substances that cannot be metabolized by the Member.

5. "Responsible Person" means the parent or guardian of a minor

with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

6. "Total Parenteral Nutrition", "TPN" means nourishment provided through the venous system to Members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

POLICY

A. NUTRITIONAL ASSESSMENT AND THERAPY

1. The Division shall require a nutritional assessment for a Member who has been identified as having a health status which may improve or be maintained with nutritional interventions.

2. The Division shall require a nutritional assessment as determined medically necessary and as a part of health risk assessment and

screening services provided by the Member's Primary Care Provider (PCP) be covered.

3. The Division shall require Nutritional assessment services provided by a registered dietitian also are covered when ordered by the Member's PCP.

4. The Division shall require nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a Member's daily nutritional and caloric intake be covered.

5. The Division shall ensure nutritional supplementation is procured and funded for any other nutritional supplementation medically necessary for Women, Infants, and Children (WIC) exempt formula.

6. The Division shall implement protocols for transitioning a Member who is receiving nutritional therapy to or from subcontractors or providers.

B. PRIOR AUTHORIZATION

1. The Division shall require Prior Authorization (PA) for commercial oral nutritional supplements, enteral nutrition, and parenteral nutrition unless:
   a. The Member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained; or
   b. For the first 30 days with Members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition, i.e. post-hospitalization.

C. COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

1. The Division shall require the Member's PCP or specialty provider to determine the medical necessity for commercial oral nutritional supplements on an individual basis using the criteria specified in this policy.
2. The Division shall require the PCP or specialty provider to use AMPM Attachment 310-GG (A) to obtain authorization.

3. The Division shall require AMPM Attachment 310-GG (A) be used when assessing the medical necessity of providing commercial oral nutritional supplements.

4. The Division shall require the Member meet each of the following requirements in order to obtain medically necessary oral nutritional supplements:

   a. The Member is currently underweight with a Body Mass Index (BMI) of less than 18.5, presenting serious health consequences for the Member, or has already demonstrated a medically significant decline in weight within the past three months prior to the assessment;

   b. The Member is not able to consume or eat more than 25% of their nutritional requirements from typical food sources;

   c. The Member has been evaluated and treated for medical conditions that may cause problems with weight gain and growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal

problems); and

d. The Member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

5. The Division shall require the provider to submit AMPM Attachment 310-GG (A), along with supporting documentation from the Division's Medical Director or designee's consideration, demonstrating the risk posed to the Member in approving the provider's PA request, if it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the Member's overall health.

6. The Division shall require supporting clinical documentation received with AMPM Attachment 310-GG (A) is provided to the authorizing health plan that demonstrates the Member meets all of the following required criteria:

   a. Initial Requests:

i. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the Member by the PCP or specialty provider, or through consultation with a registered dietitian;

ii. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the Member meeting all of the required criteria listed in AMPM Attachment 310-GG (A). The physical assessment shall include the Member's current and past height, weight, and BMI;

iii. Documentation detailing alternatives that were tried in an effort to boost caloric intake or changes in food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as Member adherence to the prescribed dietary

plan and alternatives attempted.

b. Ongoing Requests:

i. Subsequent submissions shall include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request that includes the Member's overall response to supplemental therapy and justification for continued supplement use. This shall include the Member's tolerance, recent hospitalizations, current height, weight, and BMI;

ii. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the Member from supplemental nutritional feedings should be included, when appropriate;

iii. Members receiving nutritional therapy shall be physically assessed by the Member's PCP, specialty provider, or registered dietitian at least annually; and

iv. Initial and ongoing certificate of medical necessity is

considered valid for a period of six months.

D. METABOLIC MEDICAL FOODS

1. The Division shall require metabolic formulas and medical foods are covered for Members diagnosed with metabolic conditions that are screened for using the Newborn Screening Panel authorized by the Arizona Department of Health Services.

   p. The Division shall require Metabolic formulas and medical foods are covered as specified in A.R.S. § 20-2327 and within the following limitations:

   a. Metabolic formula or modified low protein foods shall be:

      i. Processed or formulated to be deficient in the nutrients specific to the Member's metabolic condition;

      ii. Meet the Member's distinctive nutritional requirements;

      iii. Determined to be essential to sustain the Member's optimal growth within nationally recognized height,

weight, BMI and metabolic homeostasis;

iv. Obtained under physician order; and

v. The Member's medical and nutritional status is supervised by the Member's PCP, attending physician or appropriate specialist.

b. Modified low protein foods shall be formulated to contain less than 1 gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein;

c. Soy formula is covered only for Members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and only until the Member is able to eat solid lactose-free foods;

d. Foods that are available in the grocery store or health food store are not covered as a metabolic food; and

e. Education and training is required regarding proper

sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the Member if the Responsible Person elects to prepare the Member's food.

E. TOTAL PARENTERAL NUTRITION

1. The Division shall follow Medicare requirements for the provision of Total Parenteral Nutrition (TPN) services.

2. The Division shall require TPN is covered for Members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

3. The Division shall require TPN when medically necessary, is covered for members receiving EPSDT.

F. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

   a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

G. SUPPLEMENTAL INFORMATION

For a listing of metabolic conditions and the Newborn Screening Panel refer to the Arizona Department of Health Services at https://www.azdhs.gov/documents/preparedness/state-laboratory/newborn-screening/providers/az-newborn-screening-panel-of-conditions.pdf?v=20230504.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 14:06 MST)

Anthony Dekker, D.O.

310-HH END OF LIFE CARE AND ADVANCE CARE PLANNING

EFFECTIVE DATE: June 22, 2022
REFERENCES: A.R.S §§ 36-3231, 36-551; 42 C.F.R. 489.102; AdSS 310-J, 415, 640

PURPOSE

This policy establishes guidelines for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

DEFINITIONS

1. "Advance Care Planning" is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
    a. Educate the member/responsible person about the member's illness and the health care options that are available to them.
    b. Develop a written plan of care that identifies the member's choices for treatment.
    c. Share the member's wishes with family, friends, and his or her physicians.
2. "Advance Directive" is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

3. “Curative Care” includes health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.
4. “End-of-Life Care” is a concept of care, for the duration of the member’s life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.
5. “Hospice Services” is a program of care and support for terminally ill members who meet the specified medical criteria/requirements.
6. “Practical Support” includes non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.
7. “Qualified Direct Care Worker” is an individual who demonstrates Direct Care Worker (DCW) competencies by passing the required knowledge and skills tests. The DCW Agency is responsible for determining the DCWs competency to provide care utilizing the agency’s policies and procedures, the DCW job description and the supports needs of the members served

by the DCW. In some instances, qualified DCWs may not yet be employed or contracted by a DCW Agency.

8. "Qualified Healthcare Professional" is, for the purposes of Advance Care Planning, a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or Nurse Practitioner (NP).
9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

POLICY

A. END OF LIFE CARE

The Division shall ensure that members receive End of Life (EOL) care that is member-centric, includes Advance Care Planning, and the delivery of appropriate health care services and practical supports by the AdSS and Support Coordination.

The goals of EOL care shall focus on providing treatment, comfort, and quality of life for the duration of the member's life. Care management

is provided to qualifying members/responsible persons to coordinate with treatment provider(s) to meet the member's individual needs.

EOL care is available to members under the age of 21 in conjunction with curative care and hospice care. EOL care for members aged 21 and older can be provided in conjunction with curative care until the member chooses to receive hospice care.

EOL care strives to ensure members achieve quality of life through the provision of services coordinating between the AdSS care management and Division Support Coordination to determine the services and supports necessary to meet the member's needs, including:

1. Physical and/or behavioral health medical treatment to:
    a. Treat the underlying illness and other comorbidities,
    b. Relieve pain,
    c. Relieve stress.
2. Referrals to community resources for services such as, but not limited to:
    a. Pastoral/counseling services,

b. Legal services.

3. Practical supports are non-billable services provided by a family member, friend or volunteer, who are not paid as Direct Care Workers, to assist or perform functions such as, but not limited to:

a. Housekeeping,

b. Personal care,

c. Food preparation,

d. Shopping,

e. Pet care,

f. Non-medical comfort measures.

B. ADVANCE CARE PLANNING

Advance Care Planning shall be initiated by the member's qualified healthcare professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. Advance Care Planning shall be an ongoing process for the duration of the member's life.

1. The AdSS shall ensure network providers perform the following as part of the Advance Care Planning/EOL concept of care when treating Division members:

   a. Conduct a face-to-face discussion with the member/responsible person.

   b. Educate the member/responsible person about the member's illness and the health care options that are available to the member to enable them to make educated decisions.

   c. Identify the member's healthcare, social, psychological and spiritual needs.

   d. Develop a written member centered EOL plan of care that identifies the member's choices for care and treatment, as well as life goals.

   e. Share the EOL plan with the care manager and Division Support Coordinator.

f. Share the member's wishes with appropriate designated family, friends, and specialty providers, as appropriate, his or her physicians.

g. Complete Advance Directives.

h. Complete referrals to community resources based on member's needs.

i. Assist the member/responsible person in identifying practical supports to meet the member's needs.

2. The AdSS ensures Advanced Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The service may be billed separately during a well or sick visit.

C. ADVANCE DIRECTIVES

Advance Care Planning often results in the creation of an Advance Directive for the member. Members have the right to have information provided to them about the importance of Advance Directives including their rights to establish and rescind Directives at any time.

1. The AdSS shall ensure providers comply with AdSS Medical Policy 640 pertaining to Advance Directives. At a minimum, providers shall comply with the following:

   a. Maintain written policies for adult members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an Advance Directive.

   b. Provide written information to adult members regarding the provider's policies concerning Advance Directives, including any conscientious objections.

   c. Document in the member's medical record whether or not the adult member has been provided the information, and whether an Advance Directive has been executed.

   d. Prevent discrimination against a member because of his or her decision to execute or not execute an Advance Directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive.

e. Provide education to staff on issues concerning Advance Directives including notification to staff who provide services such as home health care and personal care services (e.g., attendant care, respite, personal care) if any Advance Directives are executed by members to whom they are assigned to provide services.

f. Ensure alternative Home and Community Based Services (HCBS) setting staff have immediate access to advance directive documents to provide to first responder requests.

2. All AdSS enrolled adult members, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:

a. The member's rights, regarding Advance Directives under Arizona State law.

b. The AdSS's policies respecting the implementation of those rights, including a statement of any limitation regarding

the implementation of advance directives as a matter of conscience.

c. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. This statement, at a minimum, shall:

i. Clarify institution-wide conscientious objections and those of individual physicians,

ii. Identify state legal authority permitting such objections, and

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

d. A description of the applicable state law and information regarding the implementation of these rights.

e. The member's right to file complaints with ADHS Division of Licensing Services.

3. AdSS providers shall provide a copy of a member's executed Advance Directive or documentation of refusal, to the member's

Primary Care Provider (PCP) for inclusion in the member's medical record and provide education to staff on issues concerning Advance Directives.

D. HOSPICE SERVICES

The AdSS shall provide hospice services in accordance with Division AdSS Medical Policy 310-J.

E. TRAINING

1. The AdSS shall ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

2. The appropriate AdSS staff shall be educated in the concepts of EOL care, Advance Care Planning and Advanced Directives.

    a. Documentation of the training and attendance shall be submitted to the Division on an annual basis.

F. NETWORK ADEQUACY

The AdSS shall ensure an adequate network of providers who are trained to conduct Advance Care Planning in accordance with AdSS Operations Manual Policy 415.

G. OVERSIGHT

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS to review compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:42 PDT)
Anthony Dekker, D.O.

310-II GENETIC TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-II

PURPOSE

This policy establishes the coverage requirements and limitations of Genetic Testing for Division of Developmental Disabilities (Division) Members who are eligible for ALTCS.

DEFINITIONS

1. "Genetic Testing" means the sequencing of human Deoxyribonucleic Acid (DNA) obtained from a small sample of body fluid or tissue in order to discover genetic differences, anomalies, or mutations.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. GENETIC TESTING

1. The Division shall cover medically necessary Genetic Testing and counseling when the following criteria are met:
    a. When the Member:
        i. Displays clinical features of a suspected genetic condition;
        ii. Is at direct risk of inheriting the genetic condition in question which could be due to:
            a) A causative familial variant has been identified in a close family member, or
            b) The Member's family history indicates a high risk.
        iii. Is being considered for treatment which has significant risk of serious adverse reactions, or is ineffective, in a specific genotype.
    b. The results of the Genetic Testing are necessary to:
        i. Differentiate between treatment options;
        ii. The Member has indicated they will pursue treatment based on the results of the testing; and

iii. An improved clinical outcome is probable as evidenced by:

a) Clinical studies of fair-to-good quality published in peer-reviewed medical literature have established that actions taken as a result of the test will improve clinical outcome for the Member; or

b) Treatment has been demonstrated to be safe and likely to be effective based on the weight of opinions from specialists who provide the service or related services if the condition is rare.

c. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

d. A licensed genetic counselor or the ordering provider has counseled the Member about the medical treatment options prior to the genetic test being conducted.

2. The Division shall cover the following medically necessary Genetic Testing and counseling, irrespective of the requirements listed above:
    a. The results of the Genetic Testing will confirm either:
        i. A diagnosis and by so doing avoid further testing that is invasive and has risks of complications; or
        ii. A significant developmental delay in an infant or child and the cause has not been determined through routine testing with one of the following met:
            a) The genetic testing is limited to Chromosomal Microarray (CMA),
            b) Chromosomal testing for Fragile X, or
            c) Any further gene testing meets all other criteria in this policy.
    b. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

c. A licensed genetic counselor or the ordering provider has counseled the Member prior to the genetic test being conducted.

B. LIMITATIONS

1. The Division shall not cover Genetic Testing under the following circumstances:
   a. To determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatment of the Member except as described above in A (2)(a);
   b. To determine the likelihood of associated medical conditions occurring in the future;
   c. As a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly;
   d. For purposes of determining current or future reproductive decisions;
   e. For determining eligibility for a clinical trial; or

f. Paying for panels or batteries of tests that include one or more medically necessary tests, along with tests that are not medically necessary, when the medically necessary tests are available individually.

C. PRIOR AUTHORIZATIONS

1. The Division shall require that prior authorization requests include documentation regarding how the Genetic Testing is consistent with the Genetic Testing coverage and include:
   a. Recommendations from a licensed genetic counselor or ordering provider;
   b. Clinical findings including family history and any previous test results;
   c. A description of how the genetic test results will differentiate between treatment options for the Member or meet the requirements of section A(2)(a) or A(2)(b);
   d. The rationale for choosing one of these types of Genetic Testing:
      i. Full gene sequencing,
      ii. Deletion or duplication,

iii. Microarray, and

iv. Individual variants.

e. Medical literature citations as applicable.

D. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:

   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and

   b. Identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

SUPPLEMENTAL INFORMATION

Pursuant to A.R.S. §36-694, all babies born in Arizona are tested for specific congenital disorders through the Arizona Department of Health Newborn Screening Program. Newborn screening including confirmatory testing is not subject to the requirements of this Policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:16 MST)

Anthony Dekker, D.O.

310-KK BIOMARKER TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-KK

PURPOSE

This policy establishes the coverage requirements of Biomarker Testing for the Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention which includes gene mutations or protein expression.
2. "Biomarker Testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, which includes single-analyte tests, multiplex panel tests and whole genome sequencing.
3. "Clinical Utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy

that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

4. "Member" means the same as "Client" as defined in A.R.S. §36-551.

POLICY

A. BIOMARKER TESTING

1. The Division shall require medically necessary non-experimental Biomarker Testing is covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions when the test provides Clinical Utility as demonstrated by the following medical and scientific evidence:
    a. Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for a drug that is approved by the FDA;

b. Centers for Medicare and Medicaid Services (CMS) national coverage determinations or Medicare administrative contractor local coverage determinations, or

c. Nationally recognized clinical practice guidelines and consensus statements as outlined in A.R.S. § 20-841.13.

2. The Division shall require Biomarker Testing is covered with the same scope, duration, and frequency as the system otherwise provides to Members pursuant to A.R.S. § 36-2907.03.

3. The Division shall require that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

4. The Division shall require prior authorization for Biomarker Testing.

5. The Division shall require a clear and readily available process to accept electronic requests from providers for exceptions to a coverage policy.

6. The Division shall refer to AMPM Policy 810 for Tribal Health Plan (THP) prior authorization submission requirements.

B. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:
   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and
   b. Identify successful interventions and care pathways to optimize results.
2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:17 MST)
Anthony Dekker, D.O.

320-B MEMBER PARTICIPATION IN EXPERIMENTAL SERVICES AND CLINICAL TRIALS

EFFECTIVE DATE: March 1, 2023
REFERENCES: A.R.S. §36-1331; A.R.S. §36-1336; AMPM 320-B

PURPOSE

This policy describes the responsibilities related to Experimental Services and Qualifying Clinical Trials for Arizona Long Term Care System (ALTCS) eligible members.

DEFINITIONS

1. "Eligible Patient" means a patient who meets all of the following conditions:
    a. Has a life-threatening disease or condition or a severely debilitating illness, attested to by the patient's physician.
    b. Has considered all other treatment options currently approved by the United States Food and Drug Administration.
    c. Has received a recommendation from the patient's physician for an Individualized Investigational Treatment

based on an analysis of the patient's genomic sequence, human chromosomes, deoxyribonucleic acid, ribonucleic acid, genes, gene products, such as enzymes and other types of proteins, or metabolites.

d. Has given written informed consent for the use of the individualized investigational drug, biological product or device.

e. Has documentation from the patient's physician that the patient meets the requirements of this paragraph.

2. "Experimental Services" means a service which is not generally and widely accepted as a standard of care in the practice of medicine in the United States and is not a safe and effective treatment for the condition for which it is intended or used as specified in A.A.C. R9-22-203.

3. "Individualized Investigational Treatment" means

a. A drug, biological product or device that is unique to and produced exclusively for use by an individual patient based on the patient's own genetic profile.

b. Includes individualized gene therapy, antisense oligonucleotides and individualized neoantigen vaccines.

4. "Qualifying Clinical Trial" means any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg)(2)(A) of the Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by national organizations.

5. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the member's medical record to ensure Division members are receiving medically appropriate and high quality care.

POLICY

A. PARTICIPATION IN CLINICAL TRIALS

1. The Division shall ensure that members may participate in clinical trials if they desire, but will not reimburse for the Experimental Service.
2. The Division shall cover services related to the Qualifying Clinical Trial, including but not limited to:
    a. Routine care,
    b. Screenings,
    c. Laboratory tests,
    d. Imaging services,
    e. Physician services,
    f. Treatment of complications arising from clinical trial participation, or
    g. Other medical services and costs.
3. The Division shall not block or attempt to block an Eligible Patient's access to an Individualized Investigational Treatment.
4. The Division Medical Director shall:

a. Complete a Second Level Review of all requests for participation in Experimental Services and/or clinical trials for members.

b. Have the final authority to approve or deny the member's participation in Experimental Services and/or clinical trials.

c. Consults with the assigned AHCCCS Medical Director for Tribal Health Plan (THP) or the assigned subcontracted health plan's Medical Director when there are questions regarding the member's participation in Experimental Services and/or clinical trials.

B. COVERAGE DETERMINATION

1. The Division shall ensure coverage for a member to participate in a Qualifying Clinical Trial. Coverage shall be:

   a. Expedited and completed within 72 hours regardless of the geographic location or if the provider is in network;

   b. Based on where the clinical trial is conducted, including out of state; or

c. Based on whether the provider treating the member is outside of the network, the member may not be denied.

2. The Division's Medical Director shall review a member's participation in an FDA Phase I or Phase II clinical trial for approval. Factors for consideration for approval will include:

a. The clinical regimen is well-designed, and adequate protection of the member's welfare is assured;

b. Provider specification of the clinical trial and any associated service are not provided to prevent, diagnose, monitor, or treat complications resulting from participation in the clinical trial;

c. Verification that full financial liability for the clinical trial is taken by the researcher or the sponsor, and not be charged to, or paid by AHCCCS;

d. The trial provides adequate participant information and assures participant consent;

e. Completion of Attachment A and Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial;

f. Fees, finder's fees, or other payment for referring members for clinical trials are not received; and

g. The member's primary care provider shall not have any financial interest in the clinical trial.

3. The Division shall ensure members rights are being protected when members are approved to participate in a clinical trial.

Signature of Chief Medical Officer: Anthony Dekker (Feb 21, 2023 12:22 MST)
Anthony Dekker, D.O.

320-F HIV/AIDS TREATMENT SERVICES

REVISION DATE: 10/1/2021
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.A.C. R4-16-101

The Division of Developmental Disabilities (Division) covers medically necessary treatment services rendered by qualified providers, for members who are eligible for the Division, ALTCS, or DDD Tribal Health Program (THP), and who have been diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Division and the Administrative Services Subcontractors (AdSS) must follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. The Division and the Administrative Services Subcontractors are responsible for distributing these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS reviews new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, the Division Medical Director, the Administrative Services Medical Director, and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

A. Established treatment and pharmaceutical regimens

B. Changes in technology and treatment protocols

C. Cost implications of treatment/pharmaceutical regimens.

Monitoring

The Division and the AdSS must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens, and necessary support services (e.g., transportation) are provided within specified timelines, as defined in contractual arrangements with the Division, and that these services are used appropriately. Support services may be coordinated with existing community resources.

The AdSS must also ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by, and in accordance with, the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member‘s treating physician.

If a conflict regarding treatment or denial of treatment arises between the member‘s treating physician and the Division’s Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member‘s right to file an appeal.

HIV/AIDS Treatment Professionals

AHCCCS compiles, updates, and makes available, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners, and/or physician assistants). The listing will be based on information submitted by the Division as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

A. Is recognized in the community as having a special interest, knowledge, and experience, in the treatment of HIV/AIDS

B. Agrees to adhere to CDC treatment guidelines for HIV/AIDS

C. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS

D. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year

E. Meets one of the criteria below:

   1. Current Board Certification or Recertification in Infectious Diseases, or

   2. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.

Limitations

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Division or AdSS demonstrating that s/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation must be maintained in the Division and AdSS' credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

A. In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

B. When a member with HIV/AIDS chooses a provider who does not meet the criteria.

Contract Network

The Division and the AdSS must include in its individual provider network sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The AdSS must also have policies and procedures to assure that provider requirements and standards specified in the Division Policy Manuals and the AMPM are met. Each provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). The AdSS must submit, annually by December 15, a list of HIV/AIDS treatment providers (to the Division Health Care Services Unit, through the Compliance Unit) that includes:

A. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS

B. For each Primary Care Provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

The AdSS must also notify the Division of any material change to the HIV/AIDS provider network during the year. The Division will notify AHCCCS of any major changes.

AdSS policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the AdSS's network. If the member selects a PCP in the AdSS's network who is not a provider designated by the AdSS as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.

320-G LUNG VOLUME REDUCTION SURGERY

REVISION DATE: 4/1/2022, 10/1/2021

EFFECTIVE DATE: March 3, 2017

REFERENCES: AHCCCS Medical Policy 1100, Federal Emergency Services Program Overview; AHCCCS Medical Policy 320-G, Attachment A, US Department of Health and Human Services Centers for Medicare and Medicaid National Coverage Decision for Lung Volume Reduction Survey (Reduction Pneumoplasty)

PURPOSE

This policy establishes the requirements for the lung volume reduction surgery (LVRS) as applies to DDD subcontracted health plans as well as DDD FFS Tribal Health Program (THP).

DEFINITIONS

“Lung Volume Reduction Surgery (LVRS)” is a surgical procedure that removes diseased lung tissue. This procedure reduces the size of an over-inflated lung and allows for the expansion of the remaining (healthy) lung. Also referred to as reduction pneumoplasty, lung shaving or lung contouring.

POLICY

The Division of Developmental Disabilities (Division) covers lung volume reduction surgery (LVRS), or reduction pneumoplasty, for members eligible for ALTCS with severe emphysema. This surgery must be performed at a facility approved by Medicare in accordance with all of the established Medicare guidelines.

The Centers for Medicare and Medicaid Services (CMS) issued a National Coverage Decision (NCD) for lung volume reduction surgery (reduction pneumoplasty) specifying covered and non-covered criteria. In the event Medicare‘s policy is revised, DDD may reevaluate and/or revise its policy

accordingly. National Coverage Decision (NCD) for lung volume reduction surgery (reduction pneumoplasty) can be located in AMPM 320-G as Attachment A.

The member's treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare, the Division's Administrative Services Subcontractor (AdSS), and AHCCCS guidelines.

Prior Authorization

When requesting authorization for members enrolled in a DDD subcontracted health plan, the documentation must be sent to the health plans prior authorization team for review.

Mercy Care Toll Free 1-800-624-3879

Website: mercycare.org

4755 44th Place, Phoenix, AZ 85040

24-Hour Nurse Line: 1 (800) 624-3879 or (602) 263-3000 option 2

UnitedHealthcare Community Plan Toll Free 1-888-586-4017

Website: uhccommunityplan.com

1 East Washington, Suite 900, Phoenix, AZ 85004

24-Hour Nurse Line: 1 (877) 440-0255

For members enrolled in the DDD Tribal Health Program (THP), please contact AHCCCS at:

AHCCCS Prior Authorization (PA) Unit
AHCCCS-Division of Fee-for-Service Management Care Management System Unit (CMSU), Mail Drop 8900
701 East Jefferson Street
Phoenix, AZ 85034

1-602-417-4400 (Phoenix area direct line to the PA area)
1-800-433-0425 (In state direct line into the PA area)
1-800-523-0231 (Out of state line to AHCCCS switchboard; dial extension 602-417-4400 or ask for PA area)

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, AHCCCS may cover this procedure at out-of-state facilities, if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, the Division's subcontracted health plans, THP or AHCCCS, may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging, and board may be covered as appropriate. Please refer to each health plan's prior authorization department related to this coverage. Please refer to each health plan's prior authorization department related to this coverage.

Signature of Chief Medical Officer: Anthony Dekker
Anthony Dekker (Mar 30, 2022 14:31 PDT)

320-I TELEHEALTH AND TELEMEDICINE

REVISION DATE: 12/21/2022, 10/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 U.S.C. 1396d, A.R.S. § 36-3602, A.R.S. § 36-3605, A.R.S. § 36-3606, A.R.S. § 36-3607, AMPM 310-P, AMPM Policy 431, AMPM 670, AMPM 820, ACOM 436.

PURPOSE

This policy describes covered Telehealth and Telemedicine services for Division of Developmental Disability (DDD) members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Asynchronous" means the transfer of data from one site to another through the use of a camera or similar device that records an image that is sent via Telecommunication to another site for consultation. Asynchronous applications would not be considered Telemedicine but may be utilized to deliver services. Asynchronous services are rendered after the initial collection of data from the member and are provided without real-time interaction with the member.

2. "Consulting Provider" means any Arizona Health Care Cost Containment System (AHCCCS)-registered provider who is not located at the Originating Site who provides an expert opinion to assist in the diagnosis or treatment of a member.

3. "Distant Site" means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via Telecommunications system.

4. "Originating Site" means the location of the patient at the time the service being furnished via a Telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service. The Place of Service (POS) on the service claim is the Originating Site.

5. "Synchronous" means the "real time" two-way interaction between the member and provider, using interactive audio and video.

6. "Telecommunications Technology" (which includes Asynchronous applications) means the transfer of medical data from one site to

another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records an image which is then sent via Telecommunication to another site for consultation. Services delivered using Telecommunications Technology, but not requiring the member to be present during their implementation, are not considered Telemedicine.

7. "Teledentistry" means the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by a AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

8. "Telehealth" means the use of Telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distances.

9. "Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the Originating and Distant Sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

POLICY

A. TELEHEALTH

1. The Division shall cover medically necessary, non-experimental, and cost-effective services delivered via Telehealth for Division covered services.

2. The Division shall cover services delivered via Telehealth in rural and urban regions; there are no geographic restrictions for Telehealth.

3. The Division shall not limit or deny the coverage of services provided through Telehealth and shall apply the same limits or exclusions on a service provided through Telehealth that are applicable to an in-person encounter for the same service,

except for services for which the weight of evidence, determines the service not to be appropriate to be provided through Telehealth, based on:

a. Practice guidelines,

b. Peer-reviewed clinical publications or research, or

c. Recommendations by the telehealth advisory committee on Telehealth best practices.

4. The Division shall not permit services delivered via Telehealth to replace member or provider choice for healthcare delivery modality.

5. The Division shall ensure a provider makes a good faith effort in determining both of the following:

   a. Whether a service should be provided through Telehealth instead of in-person. The provider shall use clinical judgment in considering whether the nature of the services necessitates physical interventions and close observation and the circumstances of the member, including:

i. Diagnosis,

ii. Symptoms,

iii. History,

iv. Age,

v. Physical location, and

vi. Access to Telehealth.

b. The communication medium of Telehealth and whenever reasonably practicable, the Telehealth communication medium that allows the provider to most effectively assess, diagnose and treat the member. Factors the provider may consider in determining the communication medium include:

i. The member's lack of access to or inability to use technology, or

ii. Limits in Telecommunication infrastructure necessary to support interactive Telehealth encounters.

6. The Division may allow a provider who is not licensed within the State of Arizona to provide Telehealth services to a member located in the state if the following conditions are met:
   a. The provider is an AHCCCS-registered provider, and
   b. The provider complies with all requirements listed within A.R.S. § 36-3606.

B. TELEMEDICINE SERVICES

1. The Division shall cover Telemedicine services, including health care delivery, diagnosis, consultation, treatment, and the transfer of medical data through real-time Synchronous interactive audio and video communications that occur in the physical presence of the member.

2. The Division shall reimburse providers at the same level of payment for equivalent services as identified by Healthcare Common Procedure Coding System (HCPCS) whether provided via Telemedicine or in-person.

C. ASYNCHRONOUS SERVICES

1. The Division shall provide reimbursement for consultation limited to clinically appropriate services that are provided without real-time interaction. Reimbursement is limited to the following services:
    a. Dermatology,
    b. Radiology,
    c. Ophthalmology,
    d. Pathology,
    e. Neurology,
    f. Cardiology,
    g. Behavioral Health,
    h. Infectious Diseases, or
    i. Allergy/Immunology.

D. E-CONSULT SERVICES

1. The Division shall cover medically necessary e-consult visits, to aid in the coordination of care between a Primary Care Provider

(PCP) and a specialist, and to improve timely access to specialty providers.

E. REMOTE PATIENT MONITORING SERVICES

1. The Division shall cover both Synchronous and Asynchronous remote patient monitoring.
2. The Division shall limit coverage of equipment and/or supplies for remote patient monitoring to when:
   a. The service being provided is an Division covered service eligible for remote monitoring, and
   b. The equipment and/or supplies are Division covered items.

F. AUDIO-ONLY SERVICES

1. The Division shall cover audio-only services if a Telemedicine encounter is not reasonably available due to the member's functional status, the member's lack of technology or Telecommunications infrastructure limits, as determined by the provider.
2. The Division shall reimburse providers at the same level of payment for equivalent in-person mental health and substance

use disorder services, as identified by HCPCS, if provided through Telehealth using an audio-only format.

G. TELEDENTISTRY SERVICES

1. The Division shall cover Teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider.

2. The Division shall cover Teledentistry including the provision of preventative and other approved therapeutic services by the AHCCCS-registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

3. The Division shall not use Teledentistry to replace the dental examination by the dentist. Limited exams may be billed through the use of Teledentistry. Periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

H. CONDITIONS AND LIMITATIONS

1. The Division shall ensure all Telehealth reimbursable services are provided by an AHCCCS-registered provider within their scope of practice.

2. The Division shall cover Non-Emergency Transportation (NEMT) to and from the Originating Site where applicable.

3. The Division shall ensure services provided through Telehealth or resulting from a Telehealth encounter are subject to all applicable statutes and rules that govern prescribing, dispensing and administering prescription medications and devices.

4. The Division shall ensure informed consent standards for Telehealth services adhere to all applicable statutes and policies governing informed consent.

5. The Division shall ensure privacy and confidentiality standards for Telehealth services adhere to all applicable statutes and policies governing healthcare services, including the Health Insurance Portability and Accountability Act (HIPAA).

6. The Division shall not place Place Of Service (POS) restrictions for a Distant Site.

7. The Division may qualify Telehealth as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC) visit, if all other applicable conditions in this Policy are met.

I. SUPPLEMENTAL INFORMATION

1. The AHCCCS Telehealth code set defines which codes are billable, the applicable modifier(s) and place of service that providers must use when billing for the following services when provided through remote patient monitoring:
   a. Telemedicine services,
   b. Asynchronous services,
   c. E-consult services,
   d. Remote patient monitoring services, and
   e. Audio-only services.

2. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient

monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of Telemedicine, they are often considered under the broad umbrella of Telehealth services. Even though such technologies are not considered Telemedicine, they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services.

Signature of Chief Medical Officer: Anthony Dekker (Dec 19, 2022 08:06 MST)
Anthony Dekker, D.O.

320-K TOBACCO CESSATION PRODUCT POLICY

EFFECTIVE DATE: March 3, 2017

REFERENCES: AHCCCS Medical Policy Manual Exhibit 320-K-1

The Division of Developmental Disabilities (Division) covers tobacco cessation products, ordered by a Primary Care Provider (PCP), which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who are eligible for the ALTCS who wish to stop using tobacco. The Division encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

The following criteria apply to members choosing to receive a tobacco cessation product.

A. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

B. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. This includes all tobacco cessation products, including those that are available over-the-counter.

C. The maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period. The six-month period begins on the date the pharmacy fills the first tobacco cessation product.

D. The Division has adopted the prior authorization protocol described in AHCCCS Medical Policy Manual Exhibit 320-K-1, which must be followed by the Administrative Services Subcontractors.

320-M MEDICAL MARIJUANA AND CBD OIL PRODUCTS

REVISION DATES: 7/13/2022, 1/15/2020, 04/17/2015
EFFECTIVE DATE: March 2, 2015
REFERENCES: 9 A.A.C. 22, Article 2, 42 CFR 440.120, AMPM 320-M Medical Marijuana

PURPOSE

This policy applies to members who receive services from the Division and vendors and subcontractors who provide services to Division members. This policy establishes requirements for the coverage and use of medical marijuana and all cannabidiol (CBD) products (regardless of plant derivation).

DEFINITIONS

1. "AHCCCS Registered Provider" means a contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS-covered services.
2. "Medical Marijuana" means products that are a cannabis product requiring a medical marijuana card and are sold in a Marijuana Dispensary or a CBD Oil store.

POLICY

A. Medical Marijuana and CBD Products

The Division covers medically necessary federally and state reimbursable medications prescribed by a physician, physician assistant, nurse practitioner, dentist or other AHCCCS approved practitioner and dispensed by a licensed AHCCCS registered pharmacy, as defined in 9 A.A.C. 22, Article 2. Under 42 CFR 440.120 Medical Marijuana or CBD Oil products do not qualify as federally reimbursable medications. The Division does not cover medical marijuana or CBD Oil. The Division will not provide reimbursement for an office visit, these products or any other services that are primarily for the purpose of determining if a member would benefit from medical marijuana. The Division recognizes that AHCCCS registered providers operating within the scope of their license may recommend the use of medical marijuana or CBD Oil although it is not a covered benefit.

Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee, subcontractor, volunteer, and staff of the Division's service providers administer or

store medical marijuana or CBD Oil products (regardless of the plant) for Division members. Examples of medical marijuana products would include marijuana plants, pre-rolled marijuana cigarettes, marijuana edibles, marijuana vaping products etc.

B. FDA Approved Cannabidiol Products

This policy does not apply to the prescribing or administering of FDA approved medications that may include cannabidiol or its components. Under Federal Law, there are currently prescription medications commercially available that contain cannabidiol ingredients. Medications such as Epidiolex™ (cannabidiol) and Marinol™ (dronabinol), are allowed because they are FDA approved products requiring a prescription and dispensed by an AHCCCS registered pharmacy.

Signature of Chief Medical Officer: Anthony Dekker (Jul 6, 2022 12:06 PDT)
Anthony Dekker, D.O.

320-O BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

REVISION DATE: 10/1/2021
EFFECTIVE DATE: March 3, 2021
REFERENCES: A.R.S. § 32-2061, A.R.S. § 32-2091, A.R.S. § 32-3251 et seq., A.R.S. § 36-501; A.A.C. R4-6-101, A.A.C. R9-10, A.A.C R9-21

PURPOSE

The Division covers behavioral health assessments and treatment/service planning for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing behavioral health assessments and treatment/service planning to members are outlined in this policy including additional requirements for members that have chosen THP as their Health Plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for THP members. See AdSS Policy 320-O for responsibilities of the AdSS providing behavioral health assessments and treatment/service planning.

DEFINITIONS

Behavioral Health Assessment is the ongoing collection and analysis of an individual's medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Behavioral Health Professional (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091,
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:

a. A psychiatric-mental health nursing certification, or

b. One year of experience providing behavioral health services.

Behavioral Health Technician (BHT) as specified in A.A.C. R9-10-101, an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

2. Are provided with clinical oversight by a behavioral health professional.

DESIGNATED REPRESENTATIVE for purposes of this Policy, an individual chosen by a member who carries a serious mental illness designation and has been identified by AHCCCS Special Assistance. The Designated Representative protects the interests of the member during service planning, inpatient treatment discharge planning, and the SMI grievance, investigation or appeal process.

Health Care Decision Maker is an individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an un-emancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

Health Home is a provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center, or an Integrated Care Provider. Members may or may not be formally assigned to a Health Home.

Service Plan is a complete written description of all covered health services and other informal supports which includes individualized goals, peer and recovery support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Treatment Plan is a written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multispecialty, interdisciplinary team.

Requirements for Behavioral Health Providers

A. Overview

1. The model for behavioral health assessment, treatment/service planning and service delivery shall be strength-based, member-centered, family-friendly, based on voice and choice, culturally and linguistically appropriate, and clinically supervised.

2. The model incorporates the concept of a "team," established for each member receiving behavioral health services.

3. The model is based on four equally important components:

   a. Input from the member, or when applicable the health care decision maker and designated representative regarding the member's needs, strengths, and preferences;

   b. Input from other individuals involved in the member's care who have important relationships with the member;

   c. Development of a therapeutic alliance between the member, or when applicable the health care decision maker and the designated representative, and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality; and

   d. Clinical expertise/qualifications of individuals conducting the assessment, treatment/service planning, and service delivery.

2. For children, this team is the Child and Family Team (CFT). For adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

   a. Ongoing engagement of the member, or when applicable the health care decision maker, and the designated representative, family, assigned Support Coordinator, and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment. The member's Support Coordinator must participate in all CFT and ART meetings.

   b. An assessment process that is conducted to:

      i. Elicit information on the strengths and needs of the member and his/her family,

      ii. Identify the need for further or specialty evaluations, and

      iii. Support the development and updating of the treatment/service plan which effectively meets the member and family needs and results in improved health outcomes.

   c. Continuous evaluation of treatment effectiveness through the CFT or ART process, the ongoing assessment of the member, and input from the member, or when applicable the health care decision maker, and the designated representative, and Support Coordinator, resulting in modification to the treatment plan, as necessary.

d. Provision of all covered services as identified on the treatment/ service plan(s), including assistance in accessing community resources as appropriate.

e. For children, services are provided consistent with the Arizona Vision - 12 Principles as specified in the AMPM Policy 100 and the AHCCCS Child and Family Team Behavioral Health System Practice Tool. For adults, services are provided consistent with the Adult Service Delivery System - 9 Guiding Principles.

f. Ongoing collaboration with other people and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, specialty service providers, school, child welfare, AdSS, justice system and others). This shall include sharing of clinical information as appropriate.

g. Ensure continuity of care by assisting members who are transitioning to a different treatment program, changing behavioral health providers, and/or transferring to another service delivery system (e.g., out of state). For more details see AdSS Operations Policy 402 and Division Medical Policy 520.

3. At least one Peer Recovery Support Specialist may be assigned to each ART to provide covered services, when appropriate, and provide access to peer support services for individuals with Substance Use Disorders, including Opioid Use Disorders, for purposes of navigating members to Medication Assisted Treatment (MAT) and increasing participation and retention in MAT treatment and recovery supports.

4. The Division requires subcontractors and subcontractor providers to make available and offer the option of having a Family Support Specialist for each CFT, to provide covered services when appropriate.

B. Assessment and Service Planning

Regardless of the Health Plan, including the Division's THP, the member is enrolled with the following requirements must be met. For members enrolled in THP, the Division's Support Coordinator is responsible for coordinating care between the physical health provider and behavioral health provider including Tribal Behavioral Health Authorities (TRBHA). Support Coordinators can request the Behavioral Health Administration and Health Care Services to assist in care coordination activities for THP members.

1. General Requirements for behavioral health assessments and treatment/service planning shall comply with the Rules in A.A.C. R9-10 and A.A.C. R9-21, as applicable. AMPM 320-O, Attachment A, shall be utilized by the member, or when applicable the health care decision maker, and the designated representative to indicate agreement or disagreement with Service Plan and awareness of rights to appeal

process if not in agreement with Service Plan.

2. Assessments, Service and Treatment Plans shall be completed by BHPs or BHTs under the clinical oversight of a BHP.

3. Behavioral health providers outside of the Health Home may complete assessment, service and treatment planning to support timely access to medically necessary behavioral health services as allowed under licensure. (A.A.C. R9, et. seq.)

    a. Should a specialty provider complete any type of behavioral health assessment, the specialty provider shall communicate with the Health Home regarding assessment findings. In situations where a specific assessment is duplicated and findings are discrepant, specialty provider and Health Home BHP or BHT shall discuss the differences and clinical implications for treatment needs. Differences shall be addressed within the CFT with participation from both the Health Home and Specialty Provider,

    b. Behavioral health providers shall supply completed Assessment and Service and Treatment Plan documentation to the Health Home for inclusion in the member's medical record,

    c. The assessment and service planning shall be implemented to align, as much as possible, with the Division's assessment and service planning, and

    d. For those Division members that have also been determined SMI, service planning and treatment shall be implemented to align with all requirements for SMI members under Division, AHCCCS and State of Arizona policy and rules including Division Medical Policies 310-B, 320-P, 320-Q and 320-R; Division Operational Policies 444 and 446.

4. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) shall be met.

5. At a minimum, the member, or when applicable the health care decision maker, and the designated representative, and a BHP, shall be included in the assessment process and development of the treatment/service Plan.

6. The assessment and treatment/service plan must be included in the clinical record in accordance with Division Medical Policy 940.

7. The treatment/service plan shall be based on the current assessment and identify the specific services and supports to be provided, as specified in Division Medical Policy 310-B. The Treatment Plan shall be developed based on specific treatment needs (e.g., out-of-home services, specialized behavioral health

therapeutic treatment for substance use or other specific treatment needs). Services within the Treatment/Service Plan are based on the range of services covered under AHCCCS policies.

8. The behavioral health provider shall document whether the member, or when applicable the health care decision maker, and the designated representative agrees with the treatment/service plan by either a written or electronic signature on the Service or Treatment Plan.

9. The member, or when applicable the health care decision maker, and the designated representative shall be provided with a copy of his/her service plan within seven calendar days of completion of the service plan and/or upon request.

10. SMI determination shall be completed for members who request an SMI determination in accordance with Division Medical Policy 320-P.

11. For members determined SMI:

    a. Assessment and treatment/service planning shall be conducted in accordance with A.A.C. R9-21-301 et seq. and A.A.C. R9-21-401 et seq.

    b. Special Assistance assessment shall be completed in accordance with Division Medical Policy 320-R.

    c. The completed treatment/service plan must be signed by the member, or when applicable the health care decision maker and the designated representative, in accordance with A.A.C. R9-21-308.

    d. For appeal requirements see A.A.C. R9-21-401 et seq. and Division Operations Policy 444.

12. The Health Home is responsible for maintaining the comprehensive assessment and conducting periodic assessment updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.

13. Behavioral Health Assessments, Treatment and Service Plans shall be updated at a minimum of once annually, or more often as needed, based on clinical necessity and/or upon significant life events including but not limited to:

    a. Moving,

    b. Death of a friend or family member,

    c. Change in family structure (e.g., divorce, incarceration),

    d. Hospitalization,

e. Major illness of member or family member,

f. Incarceration, and

g. Any event which may cause a disruption of normal life activities.

14. The Health Home is responsible for maintaining the treatment/service plan and conducting periodic treatment/service plan updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.

15. The Health Home shall coordinate with any entity involved in the member's Behavioral Health Assessment and Treatment and Service Planning care. (Refer to Division Medical Policy 541)

16. Special Circumstances:

a. Children Age 6 through 17 - An age-appropriate assessment shall be completed by the Health Home during the initial assessment and updated at least every six months, and this information shall be provided to the TRBHA or Division,

b. Children Age 6 through 17 - Strength, Needs and Culture Discovery Document shall be completed, as deemed appropriate, by the Health Home, and this information shall be provided to the TRBHA or Division, and

c. Children Age 11 through 17 - Standardized substance use screen and referral for further evaluation when screened positive shall be completed by the Health Home, and this information shall be provided to the TRBHA or Division.

E. Crisis and Safety Planning

1. General Purpose of a Crisis and Safety Plan

A Crisis and Safety Plan provides a written method for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis. The Crisis and Safety Plan shall be developed in accordance with the Vision and Guiding Principles of the Children's System of Care and the Nine Guiding Principles of the Adult System of Care as specified in AMPM Policy 100. Crisis and Safety plans shall be trauma informed with a focus on safety and harm reduction.

The development of a Crisis and Safety Plan shall be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior Plan, if applicable. It shall be considered when clinically indicated. Clinical indicators may include, but are not limited, needs identified in members Treatment, Service, or Behavior Plan in addition to any one or a combination of the following:

a. Previous psychiatric hospitalizations,

b. Out-of-home placements,

c. HCBS settings,

d. Nursing facilities,

e. Group Home settings,

f. Special Health Care Needs,

g. Court-Ordered Treatment,

h. History of DTS/DTO,

i. Individuals with an SMI designation, and

j. Individuals identified as high risk/high needs.

Crisis and Safety Plans shall be updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the Crisis and Safety Plan shall be distributed to the team members that assisted with development of the Crisis and Safety Plan.

A Crisis and Safety Plan does not replace or supplant a Mental Health Power of Attorney or behavior plan, but rather serves as a compliment to these existing documents.

2. Essential Elements

A Crisis and Safety Plan shall establish goals to prevent or ameliorate the effects of a crisis and shall specifically address:

a. Techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the CFT or ART,

b. Identification of realistic interventions that are most helpful or not helpful to the individual and his/her family members or support system,

c. Reduction of symptoms,

d. Guiding the support system toward ways to be most helpful,

e. Any physical limitations, comorbid conditions, or unique needs of the member (e.g., involvement with DCS or Special Assistance),

f. Adherence to Court-Ordered Treatment (if applicable),

g. Necessary resources to reduce the chance for a crisis or minimize the effects of an active crisis for the member. This may include but is not limited to:

i. Clinical (support staff/professionals), medication, family, friends, parent, guardian, environmental,

ii. Notification to and/or coordination with others, and

iii. Assistance with and/or management of concerns outside of crisis (e.g., animal care, children, family members, roommates, housing, financials, medical needs, school, work).

F. AdSS Oversight

The Division completes an annual Operational Review of each AdSS. Compliance with this policy and associated procedures may be reviewed during the Annual Operational Review. Each AdSS is expected to comply with requirements described in the associated AdSS Policy 320-O, Behavioral Health Assessments and Treatment/Service Planning

320-P SERIOUS EMOTIONAL DISTURBANCE AND SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATIONS

REVISION DATE: 2/7/2024
REVIEW DATE: 9/19/2023
EFFECTIVE DATE: July 14, 2021
REFERENCES: A.R.S. 36-550, A.A.C. R9-21-101(B), AMPM Policy 320-P

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and establishes requirements for eligibility determinations for individuals with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI).

Further, this policy describes requirements for Division oversight and monitoring of duties delegated to Administrative Services Subcontractors (AdSS) as specified in contract and AdSS Medical Policy 320-P.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday or Friday, excluding State and Federal Holidays.

2. "Determining Entity" means an entity designated by Arizona Health Care Cost Containment System (AHCCCS) and authorized to make SED and SMI eligibility determinations, or a Tribal Regional Behavioral

Health Authority (TRBHA) authorized to make the final determination of SED or SMI eligibility.

3. "Designated Representative" means an individual parent, guardian, relative, advocate, friend, or other individual, designated orally or in writing by a Member or Responsible Person who, upon the request of the Member, assists the Member in protecting the Member's rights and voicing the Member's service needs.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Removal of Serious Emotional Disturbance Designation" means the process that results in the removal of the SED behavioral health category from the individual's most recent, active enrollment segment.

6. "Removal of Serious Mental Illness Designation" means the process that results in a modification to a Member's medical record by changing the behavioral health category designation from SMI to General Mental Health.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been

appointed.

8. "Serious Emotional Disturbance" means a designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

9. "Serious Mental Illness" means a designation as defined in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

10. "Serious Emotional Disturbance or Serious Mental Illness Eligibility Determination" means a process used to determine whether an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SED or SMI services.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure all Members from birth to 18 years of age are evaluated for SED eligibility by a qualified clinician and have an SED eligibility determination made by the Determining Entity if the Responsible Person or Designated Representative makes such a request.

2. The Division shall ensure all Members age 17.5 or older are evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and have an SMI eligibility determination made by the Determining Entity if:
   a. The Member or Designated Representative makes the request,
   b. An Arizona Court issues an order instructing a Member to undergo an SMI Evaluation,
   c. It is clinically indicated by the presence of a qualifying diagnosis, or
   d. There is reason to believe that the assessment may indicate the presence of a qualifying diagnosis and functional limitation(s), and
   e. The actual SMI eligibility category will not become effective until a member turns 18 years of age.

3. The Division shall require the SED and SMI eligibility evaluation records contain all documentation considered during the review, including current and historical treatment records, and may be maintained in either hardcopy or electronic format.

4. The Division shall provide assistance and guidance on SED and SMI eligibility evaluation record location and maintenance, if needed.

5. The Division shall use computation of time during the SED and SMI determination process as follows:
    a. Day zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment.
    b. Day one: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the Determining Entity as soon as practicable, but no later than 11:59 pm on day one.
    c. Day three: The third business day after the initial assessment is completed. The Determining Entity shall have at least two business days to complete the final SMI determination, but the final SMI determination must be

completed no later than day three.

d. Determination due date: Day three, three business days after day zero, excluding weekends and holidays, and is the date that the determination decision must be rendered. This date may be amended if an extension is approved in accordance with this policy.

B. PROCESS FOR COMPLETION OF THE INITIAL SED OR SMI ASSESSMENT

1. The Division shall require behavioral health providers, upon receipt of a request, referral, or identification of the need for an SED or SMI determination, to schedule an assessment with the Member and a qualified clinician if one has not been completed within the past six months.
   a. Assessments are to be scheduled as expeditiously as the Member's health condition requires, but no later than seven business days after receipt of the request or referral.
   b. For urgent eligibility determination referrals for Members admitted to a hospital for psychiatric reasons, the Determining Entity is able to accept an assessment completed by the hospital if it meets the criteria needed to

render a decision.

2. During the assessment meeting with the Member, the qualified clinician shall:

   a. Make a clinical judgment as to whether the Member is competent to participate in an evaluation;

   b. Obtain written consent to conduct the assessment from the Member, or if applicable the Member's Responsible Person, unless the Member has been ordered to undergo evaluation as part of court-ordered treatment proceedings;

   c. Provide to the Member, and if applicable the Member's Responsible Person, the information required in A.A.C. R9-21 301(D)(2), a Member rights brochure, and the Member's notice of right to appeal required by A.A.C. R9-21- 401(B);

   d. Obtain authorization for the release of information, if applicable, for any documentation that would assist in the determination of the Member's eligibility for SED or SMI designation;

   e. Conduct an assessment that is an accurate representation of the Member's current level of functioning if one has not

been completed within the past six months;

f. Complete the SED or SMI determination packet on the AHCCCS SMI Provider Submission Portal; and

g. Upon completion, submit all information to the Determining Entity within one business day.

C. CRITERIA FOR SED ELIGIBILITY

1. The Division shall require the final determination of SED to include both a qualifying SED diagnosis and functional impairment because of the qualifying diagnosis.

2. The Division shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. To meet the functional criteria for SED status, the Division shall require, as a result of a qualifying diagnosis, dysfunction in at least one of the following four domains for most of the past six months or for most of the past three months with an expected continued duration of at least three months:

   a. Seriously disruptive to family or community:

      i. Pervasively or imminently dangerous to self or others' bodily safety;

ii. Regularly engages in assaultive behavior;

iii. Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior;

iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education or personal relationships

b. Dysfunction in role performance:

i. Frequently disruptive or in trouble at home or at school;

ii. Frequently suspended or expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised school setting;

v. Performance significantly below expectation for cognitive or developmental level; or

vi. Unable to attend school or meet other developmentally appropriate responsibilities.

c. Child and Adolescent Level of Care Utilization System

(CALOCUS) recommended level of care 4, 5, or 6.

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing, and remitting course;

ii. Comorbidities including developmental or intellectual disability, substance use disorder, or personality disorders;

iii. Persistent or chronic factors, such as social isolation, poverty, extreme chronic stressors; or

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers.

4. The Division shall not allow the following reasons alone to be sufficient for denial of SED eligibility:

a. An inability to obtain existing records or information; or

b. Lack of a face-to-face psychiatric or psychological evaluation.

D. CRITERIA FOR SMI ELIGIBILITY

1. The Division shall require the final determination of SMI to include a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

2. The Division shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. To meet the functional criteria for SMI status, the Division shall require, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains for most of the past 12 months or for most of the past six months with an expected continued duration of at least six months:
    a. Inability to live in an independent or family setting without supervision:
        i. Neglect or disruption of ability to attend to basic needs;
        ii. Needs assistance in caring for self;
        iii. Unable to care for self in a safe or sanitary manner;
        iv. Housing, food and clothing is provided or arranged for by others;
        v. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental

care;

vi. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions;

vii. Refuses treatment for life threatening illnesses because of behavioral health disorder; or

viii. A risk of serious harm to self or others.

b. Seriously disruptive to family or community:

i. Pervasively or imminently dangerous to self or others' bodily safety;

ii. Regularly engages in assaultive behavior;

iii. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior;

iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education, livelihood, career, or personal relationships.

c. Dysfunction in role performance:

i. Frequently disruptive or in trouble at work or at school;

ii. Frequently terminated from work or suspended/ expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised work or school setting;

v. Performance significantly below expectation for cognitive/developmental level;

vi. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Comorbidities including developmental or intellectual disability, substance use disorder, personality disorders;

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors; or

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, or care is complicated and requires multiple providers.

4. The Division shall not allow the following reasons alone to be sufficient for denial of SMI eligibility:
   a. An inability to obtain existing records or information; or
   b. Lack of a face-to-face psychiatric or psychological evaluation.

E. MEMBERS WITH CO-OCCURRING SUBSTANCE USE

1. The Division shall require the presumption of functional impairment as follows for Members with co-occurring substance use when assessing for SED or SMI eligibility:
   a. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder) functional impairment is presumed to be due to

the qualifying mental health diagnosis.

b. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis unless:

i. The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or

ii. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the Member is actively using substances or experiencing symptoms of withdrawal from substances; and

iii. To make such determinations, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability, and establish that the symptoms and resulting disability were no longer present after the 30- or 60-day period and no longer

required mental health treatment to prevent recurrence of symptoms.

c. A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:

   i. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms; and

   ii. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.

d. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.

e. For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 days or less should be considered presumptive evidence of a persistent psychotic disorder for SED or SMI eligibility purposes.

f. For Members who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances or do not experience consecutive days of

abstinence, this is not a disqualifier to initiate the SED or SMI eligibility determination process.

g. For Members who do not meet the 30-day period of abstinence, this does not preclude them from the SED or SMI eligibility determination process.

F. ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The Division shall require the evaluating agency to respond to a Determining Entity's request for additional information to make a final SED of SMI eligibility determination within three business days of receipt of the request.

2. The Division shall allow an extension of no more than 20 calendar days to initiate or complete the SED or SMI eligibility determination if the individual agrees to the extension and:
   a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;
   b. The individual fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
   c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an

assessment or evaluation;

d. The individual, or if applicable the individual's Responsible Person, requests an extension of time;

e. Additional documentation has been requested but not received; or

f. There is insufficient functional or diagnostic information to determine SED or SMI eligibility within the required time periods.

3. The Division shall ensure that "insufficient diagnostic information" means that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SED or SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

G. NOTIFICATION OF SED OR SMI ELIGIBILITY DETERMINATION

1. The Division Behavioral Health Administration shall review notifications of SED or SMI determination results received from the Determining Entity or AHCCCS Division of Fee-For-Service

Management (DFSM).

2. The Division Behavioral Health Administration shall notify the assigned Support Coordinator of the SED or SMI determination results.

3. The Division shall ensure the Member's record is updated to reflect the status of the Member's SED or SMI eligibility.

H. RE-ENROLLMENT OR TRANSFER

1. The Division shall require the following:
   a. If the Member's status is SED or SMI at disenrollment, while incarcerated, or transition to another Contractor, the Member's status shall continue as SED or SMI.
   b. A Member shall retain their SED or SMI status unless the Member's enrollment is active and a determination is made by a Determining Entity that the Member no longer meets criteria.
   c. The SMI determination process is initiated for adolescents as specified in Division Medical Policy 520.

I. REMOVAL OF SED OR SMI DESIGNATION

1. The Division shall ensure behavioral health providers are aware

of the following process for review of SED or SMI designations:

a. A review of the eligibility determination may not be requested within the first six months from the date the Member has been designated as SED or SMI eligible.

b. A behavioral health provider may request a review of a Member's SED or SMI designation from the Determining Entity:

   i. As part of an instituted, periodic review of all Members with an SED or SMI designation;

   ii. If there has been a clinical assessment that supports the Member no longer meets the functional or diagnostic criteria; or

   iii. As requested by the Member who has been determined to meet SED or SMI eligibility criteria, or their Responsible Person or Designated Representative.

c. Based on review of the request and clinical data provided, removal of the SED or SMI behavioral health category will occur if:

   i. The individual is an enrolled Member and has not

received any behavioral health service within the past six months, or

ii. The Member is determined to no longer meet the diagnostic and or functional requirements for SED or SMI designation.

d. In the event of the removal of the designation, the following shall occur:

i. The Determining Entity will inform the Member of changes that may result with the removal of the SED or SMI designation, and

ii. Provide written notice of the determination and the Member's right to appeal within 30 calendar days from the date the written notice is issued.

2. The Division shall ensure that services are continued in the event of a timely filed appeal and that services are appropriately transitioned.

J. DIVISION OVERSIGHT AND MONITORING OF ADMINISTRATIVE SERVICES SUBCONTRACTORS

1. The Division shall provide oversight and monitoring of compliance by Administrative Services Subcontractors serving

Members enrolled in a Division subcontracted health plan with respect to any contractual delegation of duties as specified in AdSS Medical Policy 320-P using the following methods:

a. Meet with the AdSS at least quarterly to provide ongoing evaluation, including data analysis, recommendations to refine processes, and address quality of care concerns.

b. Conduct an Operational Review of each AdSS on an annual basis that includes review of policy compliance.

c. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies.

SUPPLEMENTAL INFORMATION

The information contained in Sections K through M of this policy are AHCCCS requirements for the Determining Entity authorized by AHCCCS to make the final SED and SMI designation determinations.

K. DETERMINING ENTITY RESPONSIBILITY FOR COMPLETION OF FINAL ELIGIBILITY DETERMINATION

1. A licensed psychiatrist, psychologist, or nurse practitioner designated by the Determining Entity shall make a final determination as to whether the Member meets the eligibility

requirements for SED or SMI status based on:

a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician; and

b. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources and/or present or previous treating clinicians.

2. The following shall occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician that cannot be resolved by oral or written communication:

a. Disagreement regarding diagnosis: Determination that the Member does not meet eligibility requirements for SMI status shall be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the Member’s comprehensive clinical record.

b. Disagreement regarding functional impairment:

Determination that the Member does not meet eligibility requirements shall be documented by the psychiatrist, psychologist, or nurse practitioner in the Member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

3. If there is sufficient information to determine SED or SMI eligibility, the Determining Entity shall provide the Member with notice, in writing, of the eligibility determination within three business days of the initial meeting with the qualified clinician.

4. The Determining Entity shall provide notification of the eligibility determination result to AHCCCS via the AHCCCS Behavioral Health Web Portal and to the provider who completed the Assessment/evaluation through an agreed upon medium. For Division THP members, the Determining Entity shall also provide notification to AHCCCS DFSM.

5. Once an SED or SMI eligibility determination decision is made and submitted to AHCCCS, AHCCCS will update the member's

behavioral health category to SED or SMI respectively and will provide the eligibility determination documentation to the MCO of enrollment, as applicable, via the AHCCCS Secured File Transfer Protocol (SFTP) server.

L. DETERMINING ENTITY RESPONSIBILITY DUE TO ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The Determining Entity shall:
    a. Document the reasons for the delay in the Member's eligibility determination record when there is an administrative or other emergency that will delay the determination of an SED or SMI status; and
    b. Not use the delay as a waiting period before determining an SED or SMI status or as a reason for determining that the Member does not meet the criteria for SED or SMI eligibility (because the determination was not made within the time standards).

2. In situations in which the extension is due to insufficient information:
    a. The Determining Entity shall request and obtain the

additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;

b. The designated reviewing psychiatrist, psychologist, or nurse practitioner shall communicate with the Member's current treating clinician, if any, prior to the determination of an SED or SMI, if there is insufficient information to determine the Member's level of functioning; and

c. Eligibility shall be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

3. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence/reduction from substance use in order to establish a qualifying mental health diagnosis, the Member shall be notified by the Determining Entity that the determination may, with the agreement of the Member, be extended for up to 60 calendar days for an extended evaluation period. This is a 60-day period of abstinence, or reduced use from drug and/or alcohol use in order to help the reviewing

psychologist make an informed decision regarding SED or SMI eligibility.

4. This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303; however, the Member does not need to reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.

5. If the Member refuses to grant an extension, SED or SMI eligibility shall be determined based on the available information.

6. If SED or SMI eligibility is denied, the Member shall be notified of their appeal rights and the option to reapply in accordance with this policy.

M. DETERMINING ENTITY RESPONSIBILITY FOR NOTIFICATION OF SED OR SMI ELIGIBILITY DETERMINATION

1. If the Member is determined to qualify for an SED or SMI designation, this shall be reported to the Member, Responsible Person, or Designated Representative by the Determining Entity, in writing, including notice of the Member's right to appeal the decision on the form approved by AHCCCS.

2. If the eligibility determination results in a determination that the Member does not qualify for an SED or SMI designation, the Determining Entity shall provide written notice of the decision and include:
   a. The reason for denial of SED or SMI eligibility,
   b. The right to appeal, and
   c. The statement that Title XIX/XXI eligible Members will continue to receive needed Title XIX/XXI covered services. In such cases, the Member's behavioral health category assignment shall be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 14:17 MST)

Anthony Dekker, D.O.

320-S BEHAVIOR ANALYSIS SERVICES

REVISION DATE 10/1/2021

EFFECTIVE DATE: March 17, 2021

PURPOSE

This policy applies to the Behavior Analysis Services delivered to Division members enrolled in ALTCS. The Division covers Behavior Analysis Services for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing Behavior Analysis Services to members are outlined in this policy, including additional requirements for members that have chosen THP as their health plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for THP members. See AdSS policy 320-S for responsibilities of the AdSS providing behavioral analysis services.

DEFINITIONS

Behavior Analysis Services - The use of behavior analysis to assist a person to learn new behavior, increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions in accordance with A.R.S. §32-2091.

Behavior Analysis Trainee - An individual who has met the credentialing requirements of a nationally recognized behavior analyst certification board as a board certified behavior analyst, assistant behavior analyst, or a matriculated graduate student or trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum, or supervised independent fieldwork. The practice under this role requires direct and ongoing supervision consistent with the standards set by a nationally recognized behavior analyst certification board as determined by the Arizona Board of Psychologist Examiners, and in accordance with A.R.S. §32-2091.08.

Behavior Analyst - A person who is licensed pursuant to A.R.S §32-2091 to practice behavior analysis.

Behavioral Health Professional (BHP)

1) An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   a) Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

   b) Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,

2) A psychiatrist as defined in A.R.S. §36-501,

3) A psychologist as defined in A.R.S. §32-2061,

4) A physician,

5) A behavior analyst as defined in A.R.S. §32-2091,

6) A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

7) A registered nurse with:

   a. A psychiatric-mental health nursing certification, or

   b. One year of experience providing behavioral health services.

Behavior Technician - For purposes of this Policy, a paraprofessional credentialed by a nationally recognized Behavior Analyst certification board or as specified in A.A.C. R9-10-101(39), an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1) If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

2) Are provided with clinical oversight by a Behavioral Health Professional as specified in A.A.C. R9-10-101 (39).

A. PROGRAM DESCRIPTION

Regardless of the Health Plan, including the Division's THP, the member is enrolled with the following program and services are available. For members enrolled in THP, the Division's Support Coordinator is responsible for coordinating care between the physical health provider and behavioral health provider including Tribal Behavioral Health Authorities. Support Coordinators can request the Behavioral Health Administration and Health Care Services to assist in care coordination activities for THP members.

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder and/or other diagnoses as justified by medical necessity. Behavior Analysis Services are designed to accomplish one or more of the following: Increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Refer to the Behavioral Health Services Billing Matrix and Medical Coding Resources on the AHCCCS website for more information regarding required coding information, including covered settings.

B. PROVIDER QUALIFICATIONS

Behavior Analysis Services shall be directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians.

The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

The Behavior Analyst shall be responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician performs are consistent with his or her training and experience.

The Behavior Analyst shall be responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona State rules and regulations including those provisions set forth in A.R.S. §32-2091.

C. BEHAVIOR ANALYSIS ASSESSMENTS

Behavior Analysis Services are based upon assessment(s) that include standardized and/or non-standardized instruments through both direct and indirect methods.

1. Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g., Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).

2. Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors.

D. SERVICE ADMINISTRATION

Behavior Analysis Services are rendered according to an Individualized Behavior Analysis Treatment Plan which will:

1) Be developed by a Behavior Analyst, based upon an assessment completed of the member and their behaviors as described above.

2) Be person-centered and individualized to the member's specific needs.

3) Specify the setting(s) in which services will be delivered.

4) Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).

5) Identify the baseline levels of target behaviors.

6) Specify long- and short-term objectives that are defined in observable, measurable, and behavioral terms.

7) Specify the criteria that will be used to determine treatment progress and achievement of objectives.

8) Include assessment and treatment protocols for addressing each of the target behaviors.

9) Clearly identify the schedule of services planned and roles and responsibilities for service delivery.

10) Include frequent review of data on target behaviors.

11) Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.

12) Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.

13) Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.

14) Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This may include Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, the Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, Department of Child Services, and/or other state-funded programs, and others as applicable.

15) Result in progress reports at minimum every six months. Progress reports includes, but are not limited to, the following components:

    i) Member Identification,

    ii) Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications),

    iii) Assessment findings (communication, social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns), and

    iv) Outcomes (measurable objectives, progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation).

    v) Care Coordination (transition statement and individualized discharge criteria).

16) Be consistent with applicable professional standards and guidelines relating to the practice of Behavior Analysis Services as well as Arizona Medicaid laws and regulations and Arizona state behavior analyst licensure laws and regulations (A.R.S. §32-2091).

E. Oversight of AdSS provision of Behavior Analysis Services

The Division will perform an annual operational review of each AdSS and at that time may review the receipt of Behavioral Analysis Services by the AdSS covered members. In addition, during the Division's quarterly Health Plan Oversight Committee the AdSS may be requested to report on tracking and trending of these services among their covered membership.

320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

EFFECTIVE DATE: June 16, 2021

PURPOSE

This policy applies to services delivered to Division members of the DDD Tribal Health Program (THP) by establishing guidelines, as applicable, for the provision and coordination of behavioral health services regarding the pre-petition screening, court-ordered evaluation, and court-ordered treatment process. The Division is responsible for collaborating with Tribal entities and behavioral health providers to endure access to services for THP members.

DEFINITIONS

Court-Ordered Evaluation (COE) - Evaluation ordered by the court (A.A.C R9-21-101). The COE process as specified in this Policy.

Court-Ordered Treatment (COT) - Treatment ordered by the court (A.A.C R9-21-101). The COT process as specified in this policy.

Evaluation Agency - A health care agency licensed by the Arizona Department of Health Services that has been approved pursuant to A.R.S. Chapter 5 Title 36, providing those services required of such agency.

Mental Disorder - A substantial disorder of the individual's emotional processes, thought, cognition, or memory as defined in A.R.S. §36-501.

Pre-Petition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed individual. The purpose of the interview with the proposed member is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services as specified in A.R.S. § 36-501.

Screening Agency - A health care agency licensed by ADHS and that provides those services required of such agency pursuant to A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

Voluntary Evaluation - For purposes of this Policy, an inpatient or outpatient professional multidisciplinary service based on analysis of data describing the individual person's identity, biography, and medical, psychological, and social conditions that is provided after a determination that an individual willingly agrees to consent to receive the service and is unlikely to present a danger to self or others until the service is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court-ordered evaluation and requires the informed consent of the individual. Additionally, the individual must be able to manifest capacity to give informed consent.

POLICY

This Policy outlines the processes and responsibilities applicable when it is necessary to initiate COE/COT proceedings detailed in A.R.S. §§ 36-501 et seq. This process is used to ensure the safety of an individual or the safety of others when, due to an individual's mental disorder, that individual is unable or unwilling to participate in treatment. The Division's

responsibilities may vary for Pre-Petition Screening and COE based on contractual arrangements between the Division, AHCCCS, TRBHA and the counties. The Division must ensure providers responsible for the COE/COT process adhere to requirements of this Policy.

When necessary, in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible person may submit an application when another individual is alleged to be, as a result of a mental disorder:

- Danger to Self (DTS).
- Danger to Others (DTO).
- Persistently or Acutely Disabled (PAD), or
- Gravely Disabled (GD).

If the individual who is the subject of a court-ordered commitment proceeding is subject to the jurisdiction of a tribal nation, rather than the state, the laws of that tribal nation will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order are found in this Policy.

Pre-Petition Screening includes an examination of the individual's mental status and/or other relevant circumstances by a designated Screening Agency. Upon review of the application, examination of the individual and review of other pertinent information, a licensed Screening Agency's medical director or designee will determine if the individual meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition application screening indicates that the individual may be DTS, DTO, PAD or GD, the Screening Agency will file an Application for Emergency Admission for Evaluation for a COE. Based on the immediate safety of the individual or others, an emergency admission for evaluation may be necessary. The Screening Agency, upon receipt of the application must determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application excluding weekends and holidays as specified in A.R.S. § 36-520.

Based on the COE, the Evaluating Agency may petition for COT on behalf of the

individual. The subsequent hearing is the determination as to whether the individual will be court ordered to treatment as specified in A.R.S. § 36-539. COT may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the individual's designation as DTS, DTO, PAD, or GD. Individuals identified as:

- DTS may be ordered up to 90 inpatient days per year.
- DTO and PAD may be ordered up to 180 inpatient days per year, and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the individual's outpatient treatment. Before the court can order a mental health agency to supervise the individual's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the Pre-Petition Screening, COE and COT process, an individual who manifests the capacity to give informed consent pursuant to A.R.S. § 36-518 will be provided an opportunity to change the status to voluntary. Under voluntary status, the individual will voluntarily receive an evaluation and is unlikely to present as DTO/DTS during the time pending the voluntary evaluation.

Entities responsible for COE must ensure the use of the following forms prescribed in 9

A.A.C. 21, Article 5 for individuals determined to have a Serious Mental Illness (SMI) and may also use these forms for all other populations:

Although the Division may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the Division must provide policies and procedures for providers outlining these processes.

A. Licensing Requirements

Behavioral health providers who are licensed by the ADHS/Division of Public Health Licensing as a COE or COT agency must adhere to ADHS licensing requirements.

B. Pre-Petition Screening

1. Unless otherwise indicated in an Intergovernmental Agreement (IGA) with a county, Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and COEs and are required to coordinate provision of behavioral health services with the member's contractor or FFS program, responsible for the provision of behavioral health services. For additional information, visit the AHCCCS website, https://www.azahcccs.gov.

   During the Pre-Petition Screening, the designated Screening Agency must offer assistance, if needed, to the applicant in the preparation of the application for involuntary COE Any behavioral health provider that receives an application for COE (AMPM Attachment A, COE Deliverable Template) must immediately refer the application for Pre-Petition Screening and petitioning for COE to the Division-designated Pre-Petition Screening agency or county facility.

2. The Division shall develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must conform to the processes provided in A.R.S. §§ 36-501 et seq, and at a minimum address:

   a. Involuntary evaluation,

   b. Petitioning process,

   c. COE/COT process, including tracking the status of Court orders,

   d. Execution of Court orders, and

   e. Judicial Review.

C. Responsibility for Providing Pre-Petition Screening

When the Division is responsible through an IGA with a county for Pre-Petition Screening and petitioning for COE, the Division must refer the applicant to a subcontracted Pre-Petition Screening Agency.

The Pre-Petition Screening Agency must follow these procedures:

1. Provide Pre-Petition Screening within 48 hours excluding weekends and holidays.

2. Prepare a report of opinions and conclusions. If Pre-Petition Screening was not possible, the Screening Agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the Pre-Petition Screening.

3. Ensure the agency's medical director or designee review of the report if the report indicates that there is no reasonable cause to support the allegations for COE by the applicant.

4. Prepare a Petition for COE and file the petition if the Screening Agency determines that due to a mental disorder, there is reasonable cause to believe that the individual meets the criteria set forth in § 36-521(D).

5. Ensure completion of Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the individual, without immediate hospitalization, is likely to harm themselves or others.

6. Contact the county attorney prior to filing a petition if it alleges that an individual is DTO.

D. Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the individual being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application must be filed. The petition must be filed at the appropriate agency as determined by the Division. Pursuant to A.R.S. § 36-501 et seq., when considering the emergent petition process, the following apply:

1. Only applications indicating DTS and/or DTO can be filed on an emergent basis.

2. The applicant shall have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements specified in A.R.S. § 36-524.

3. The applicant shall complete an Application for Emergency Admission for Evaluation.

4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior(s) may be called to testify in court if the

application results in a petition for COE.

5. Immediately Upon receipt of an Application for Emergency Admission for evaluation and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then facility staff will immediately coordinate with local law enforcement for the detention of the individual and transportation to the appropriate facility.

6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48-hour timeframe identified above relating to an Application for Emergency Admission for Evaluation, the Medical Director of the Division will be consulted to arrange for a review of the case.

7. The Application for Emergency Admission for Evaluation may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.

8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the Application for Emergency Admission for Evaluation in accordance with A.R.S. §§ 36-524(D) and 36-525(A), which outlines criteria for a peace officer to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.

10. During the emergency admission period of up to 23 hours the following occurs:

    a. The individual's ability to consent to voluntary treatment is assessed,

    b. The individual must be offered and receive treatment to which the individual may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e.,

       seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513, and

    c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determination that the individual no longer requires an involuntary evaluation.

E. Court-Ordered Evaluation

1. If, after review of the petition for evaluation, the individual is reasonably

believed to be DTS, DTO, PAD, GD as a result of a mental disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order must specify whether the evaluation will take place on an inpatient or an outpatient basis.

a. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer and delivered to an Evaluation Agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

2. If the Pre-Petition Screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file a petition for COE. When, through an IGA with a county, the Division is contracted to provide COE, they must adhere to the following requirements when conducting COEs:

a. An individual who is reasonably believed to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,

b. An individual admitted to an Evaluation Agency must receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,

c. A clinical record must be kept for each individual that details all medical and psychiatric evaluations and all care and treatment received by the individual,

d. An individual being evaluated on an inpatient basis must be released within 72 hours if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis or unless an application for COT has been filed, and

e. On a daily basis, at minimum, an evaluation must be conducted throughout the COE process for the purpose of determining if an individual desires to be switched to a voluntary status or qualifies for discharge.

3. For information on individuals being released from COE, and on COE dispositions, refer to A.R.S. § 36-531.

F. Voluntary Evaluation

1. The Division shall require behavioral health providers who receive an application for Voluntary Evaluation to immediately refer the individual to a facility responsible for Voluntary Evaluations. The Voluntary Evaluation may be on an inpatient or outpatient basis. Voluntary Evaluation may be carried out only if chosen by the individual during the course of a Pre-Petition Screening after an application for evaluation has been made.

2. When an individual consents to Voluntary Evaluation, the evaluating agency shall follow these procedures:

a. Obtain the individual's informed consent prior to the evaluation,

b. Provide an evaluation at a scheduled time and place within five business days of the notice that the individual will voluntarily receive an evaluation, and

c. For inpatient Voluntary Evaluations, complete evaluations in less than 72 hours of receiving notice that the individual will voluntarily receive an evaluation.

3. The Division must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see Division Medical Policy 940):

a. A copy of the application for Voluntary Evaluation

b. A completed informed consent form (see Division Medical Policy 320-Q), and

c. A written statement of the individual's present medical condition.

G. Court-Ordered Treatment Following Civil Proceedings

Based on the COE, the evaluating agency may petition for COT. As specified in

A.R.S. §§ 36-501 et seq, the Division must require behavioral health providers to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD or PAD, and if no alternatives to COT exist, the Medical Director of the agency that provided the COE shall file a petition with the court for COT.

2. Any behavioral health provider filing a petition for COT must do so in

consultation with the individual's clinical team prior to filing the petition.

3. The petition shall be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation.

4. In cases of GD, a copy of the petition must be mailed to the public

fiduciary in the county of the individual's residence, or the county in which the individual was found before evaluation, and to any person nominated as guardian/legal representative. In addition, a copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

5. For information regarding court options for treatment, release, discharge, annual reviews, or COT violations, refer to A.R.S. §§ 36-540 et seq. For requirements relating to Judicial Review, see A.R.S. §§ 36-546 and 36-546.01.

a. For COT relating to DUI/Domestic Violence or other criminal offenses, refer to Division Operations Policy 423.

H. Individuals Who Are Title XIX/XXI Eligible and/or Determined to Have a Serious Mental Illness

When an individual referred for COT is Title XIX/XXI eligible and/or determined or suspected to have an SMI, the Division must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the Division Medical Policy 320-P and conduct a behavioral health assessment to identify the individual's service needs, in conjunction with the individual's clinical team, as specified in the Division Medical Policy 320-O.

2. Provide necessary COT and other covered behavioral health services in

   accordance with the individual's needs, as determined by the individual's clinical team, family members, other involved parties.

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5, and 9 A.A.C. 21, Article 5.

I. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state issued COE or COT due to a behavioral health crisis occurs off reservation.

Several Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for COE and COT, however, each tribe has its own laws that must be followed for the tribal court process.

Additional information on the history of the tribal court process, legal documents and forms, a diagram of payment structures, as well as contact information for the tribes, tribal liaisons, TRBHAs, and tribal court representatives can be found on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment.

1. Tribal (COT) for American Indian tribal members in Arizona is initiated by the tribal behavioral health staff, the tribal prosecutor or other individuals as authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether tribal COT is necessary. Tribal court orders specify the type of treatment needed.

2. Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure COT off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

3. The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition or "enforcement" of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal

court. Treatment facilities must provide treatment as identified by the tribe and recognized by the state. Attachment B (A.R.S. §12-136 Flow Chart) is a flow chart demonstrating the communication between tribal and state entities in accordance with A.R.S § 12-136

4. Contractors and providers shall comply with notice requirements as specified in A.R.S. §12-136(B) and A.R.S. §36-541.01.

5. The Division and providers shall comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX individuals with an SMI determination. When tribal providers are also involved in the care and treatment of court-ordered tribal members, the Division and providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT and when members are transitioned to services on the reservation, as applicable. The Division is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

6. The enforcement process must run concurrently with the tribal staff's initiation of the tribal court-ordered process in an effort to communicate and ensure clinical coordination with the Division. This clinical communication and coordination with the Division is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/ county court recognition of the tribal court order. The Arizona State Hospital must be the last placement alternative considered and used in this process.

7. The Court must consider all available and appropriate alternatives for the treatment and care of the member. The Court must order the least restrictive treatment alternative available (A.R.S. § 36-540(B)). The Division is expected to partner with American Indian tribes, TRBHAs, and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

8. Due to the options American Indians have regarding their health care, including behavioral health services, AHCCCS eligible American Indians may be covered and/or coordinate behavioral health services through a TRBHA, THP (Division for THP DDD ALTCS members), AHCCCS contractor, Tribal ALTCS, IHS, or 638 tribal provider.

J. Reporting Requirements

COE and COT processes, tracking, and reporting shall align with and adhere to the requirements of A.R.S. Title 36 Chapter 5 and A.A.C. Title 9 Chapter 21 including requirements for COE and COT forms as delineated in A.A.C. Title 9 Chapter 21 Article 5:

- Exhibit A - Application for Involuntary Evaluation
- Exhibit B - Petition for Court-Ordered Evaluation
- Exhibit C - Application for Emergency Admission for Evaluation

- Exhibit D - Application for Voluntary Evaluation
- Exhibit E - Affidavit
- Exhibit F - Petition for Court-Ordered Treatment
- Exhibit G - Demand for Notice by Relative or Victim
- Exhibit H - Petition for Notice
- Exhibit I - Application for Voluntary Treatment

K. Reimbursement

1. Reimbursement for court-ordered screening and evaluation services are the responsibility of the county pursuant to A.R.S. § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22.

2. Refer to Division Operations Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE.

3. Title XIX/XXI funds must not be used to reimburse COE services.

4. For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual who is an THP ALTCS DDD member shall be the responsibility of the Division.

320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

REVISION DATES: 1/10/2024, 4/6/2022, 6/16/2021, 4/22/2020
REVIEW DATE: 6/3/2023
EFFECTIVE DATE: April 24, 2019
REFERENCES: A.R.S. §§ 32-2061, 32-2091, 32-3251 et seq., 36-501; A.A.C. R9-10-101, 702, 707, 708, 715, 814; International Classification of Diseases, 10th Revision, Clinical Modification

PURPOSE

This policy sets forth the requirements for the provision of care and services provided to eligible Division of Developmental Disabilities (Division or DDD) Members in a Behavioral Health Residential Facility (BHRF) setting, including requirements for fee-for-service providers serving Members enrolled in the Division's fee-for-service Tribal Health Program (THP) in collaboration with applicable Tribal representatives and Tribal Social Services.

Further, the purpose of this policy is to establish Division requirements for oversight and monitoring of duties delegated to the Administrative Services Subcontractors (AdSS) with respect to eligible Division Members enrolled in a DDD subcontracted health plan as specified in AdSS Medical Policy 320-V.

DEFINITIONS

1. "Adult Recovery Team" means a group of individuals who, following the

nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the Member, service planning, and service delivery.

2. "AHCCCS" means the Arizona Health Care Cost Containment System.

3. "Behavioral Health Condition" means a mental, behavioral, or neurodevelopmental disorder diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification.

4. "Behavioral Health Professional" means:

   a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

      i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

      ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101;

   b. A psychiatrist as defined in A.R.S. § 36-501;

   c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. §3 2-2091;

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral health services.

5. "Behavioral Health Residential Facility" means, as defined in A.A.C. R9-10-101, a health care institution that provides treatment to a Member experiencing a behavioral health issue that limits the Member's ability to be independent or causes the Member to require treatment to maintain or enhance independence.

6. "Behavioral Health Residential Facility Staff" means any employee of the Behavioral Health Residential Facility agency including administrators, Behavioral Health Professionals and Behavioral Health Technicians.

7. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care

institution's policies and procedures, with clinical oversight by a behavioral health professional, and that if provided in a setting other than a licensed health care institution would require the individual to be licensed as a behavioral health professional under A.R.S Title 32, Chapter 33.

8. "Child and Family Team" means a group of individuals that includes, at a minimum, the child and their family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members is determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective Service Plan and can expand and contract as necessary to be successful on behalf of the child.

9. "Crisis and Safety Plan" means a written description for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis; establishes goals to prevent or ameliorate the effects of a crisis, and specifically address techniques for establishing safety, identification of realistic interventions, physical limitations or unique needs of the Member, trauma informed, and

developed in alignment with the Member's Service and Treatment Plans, and any existing behavior plan, if applicable, and adherence to court-ordered treatment when applicable.

10. "Medication Assisted Treatment" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

11. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

12. "Outpatient Treatment Team" means a group of individuals working in collaboration with the Behavioral Health Residential Facility and are actively involved in a Member's assessment, service planning, and service delivery. Outpatient Treatment Team as used throughout this policy can indicate a Child and Family Team, Adult Recovery Team, Tribal Regional Behavioral Health Authority, American Indian Medical Home, Indian Health Services, Tribally operated 638 Facility, or the Division.

13. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been

appointed.

14. "Second Level Review" means a review performed by a Division Medical Director who has clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

15. "Secure Behavioral Health Residential Facility" means the same as specified in A.R.S. § 36-425.06(B) and A.A.C. R9-10-101 (36).

16. "Service Plan" means a written description of covered health services, and other supports which may include individual goals, family support services, care coordination, and plans to help the Member better their quality of life.

17. "Treatment Plan" means a written description of all services to be provided by the Behavioral Health Residential Facility. The Treatment Plan is based on the intake assessments, outpatient Service Plan, and input from the Outpatient Treatment Team.

18. "Tribal Health Program" means a fee-for-service program administered by the Division for Title XIX/XXI eligible American Indians that

reimburses for physical and behavioral health services provided by any AHCCCS registered provider, and for Title XIX Members, that are not provided by or through the Indian Health Services tribal health programs operated under 638.

19. "Tribal Regional Behavioral Health Authority" means a tribal entity that has an intergovernmental agreement with AHCCCS, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible Members assigned by AHCCCS to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian Members as specified in A.R.S. § 36-3401, § 36-3407, and A.A.C. R9-22-1201.

POLICY

A. BEHAVIORAL HEALTH RESIDENTIAL FACILITY REQUIREMENTS

1. The Division and BHRF providers providing services to Tribal Health Program (THP) members shall adhere to the following:

   a. BHRFs are Arizona Department of Health Services licensed facilities in accordance with A.A.C. Title 9, Chapter 10,

Article 7.

b. Care and services provided in a BHRF for Tribal Health Program (THP) Members:

   i. Are based on an AHCCCS fee-for-service rate;

   ii. Require AHCCCS prior and continued authorization; and

   iii. Do not include room and board.

c. Prior and continued authorization is not required for a Member's admission to a Secure BHRF.

d. Abide by all Superior Court Orders, as specified in A.R.S § 36-550.09, for admission and duration of stay in a Secure BHRF.

e. A Child and Family Team or Adult Recovery Team is not required for THP Members to receive services.

f. A BHRF level of care is inclusive of all treatment services provided by the BHRF in accordance with the Treatment Plan created by the Outpatient Treatment Team.

g. AHCCCS is responsible for authorizations and payments for physical and behavioral health services for Members enrolled in the THP or receiving services through a Tribal

Regional Behavioral Health Authority (TRBHA).

h. Provide care coordination, if applicable, upon notification from AHCCCS Division of Fee-For-Service Management (DFSM) of admissions to and discharges from BHRFs for ALTCS eligible Members enrolled in the THP.

i. Refer to the AHCCCS fee-for-service web page for information on prior authorization requirements for THP Members.

j. BHRF fee-for-service providers adhere to the admission and discharge criteria set forth in this policy.

2. The Division's Behavioral Health Administration shall notify Support Coordination of any admissions to and discharges from BHRFs.

3. The Division shall develop medical necessity criteria for admission to, continued stay in, and discharge from a BHRF and submit the criteria to AHCCCS for approval.

4. The Division shall post the AHCCCS-approved criteria on the Division's website.

B. CRITERIA FOR ADMISSION

1. The Division shall develop criteria for admission to a BHRF that

contains the following elements:

a. Member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment level of care.

b. The Behavioral Health Condition causing the functional or psychosocial impairment is evidenced in the assessment by the following:

i. At least one area of significant risk of harm within the past three months as a result of:

a) Suicidal, aggressive, self-harm or homicidal thoughts or behaviors without current plan or intent;

b) Impulsivity with poor judgment or insight;

c) Maladaptive physical or sexual behavior;

d) Member's inability to remain safe within their environment despite environmental supports; or

e) Medication side effects due to toxicity or contraindications; and

ii. At least one area of serious functional impairment as

evidenced by:

a) Inability to complete developmentally appropriate self-care or self-regulation due to the Behavioral Health Condition;

b) Neglect or disruption of ability to attend to majority of basic needs;

c) Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective mood disorder symptoms or major psychiatric disorders;

d) Frequent withdrawal management services, which can include detox facilities, Medication Assisted Treatment and ambulatory detox;

e) Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications; or

f) Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

c. A behavioral health need for 24-hour supervision to develop adequate and effective coping skills that will allow the Member to live safely in the community.

d. Anticipated stabilization cannot be achieved in a less restrictive setting.

e. Evidence that behavioral health treatment in a less restrictive level of care has not been successful or is not available, therefore warranting a higher level of care.

f. The Responsible Person agrees to participate in treatment.

g. Agreement to participate in treatment is not a requirement for Members who are court ordered to a Secure BHRF.

h. The Member's Outpatient Treatment Team is part of the pre-admission assessment and Treatment Plan formulation, including when the documentation is created by another qualified provider. An exception to this requirement exists

when the Member is evaluated by a crisis provider, emergency department, or behavioral health inpatient facility.

i. The BHRF shall notify the Member's Outpatient Treatment Team of admission prior to creation of the BHRF Treatment Plan.

2. BHRF providers providing services to THP Members shall adhere to the above elements listed in this section.

C. EXPECTED TREATMENT OUTCOMES

1. The Division shall require treatment outcomes to align with the following:
   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in Division Medical Policy 430;
   b. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems; and
   c. The Member's individualized basic physical, behavioral, and developmentally appropriate needs.

2. The Division shall require treatment goals to be developed in

accordance with the following:

a. Specific to the Member's Behavioral Health Condition;

b. Measurable and achievable;

c. Unable to be met in a less restrictive environment or level of care;

d. Based on the Member's unique needs and tailored to the Member and family/Responsible Person choices where possible; and

e. Supportive of the Member's improved or sustained functioning and integration into the community.

D. EXCLUSIONARY CRITERIA

1. The Division shall not allow admission to a BHRF to be used as a substitute for the following:

a. Detention or incarceration.

b. Ensuring community safety in circumstances where a Member is exhibiting primarily conduct disorder behavior without the presence of risk or functional impairment.

c. Providing safe housing, shelter, supervision or

permanency placement.

d. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs, including situations when the Responsible Person is unwilling to participate in the less restrictive alternative.

e. An intervention for runaway behaviors unrelated to a Behavioral Health Condition.

E. CRITERIA FOR CONTINUED STAY

1. The Division shall develop criteria for continued stay that contains the elements listed below in Section E.(2).

2. BHRF providers providing care and services to THP fee-for-service Members shall submit to AHCCCS DFSM documentation of all participants in the treatment planning during the continued stay review process and adhere to the following elements:

a. Assessment of continued stay by the BHRF Staff in coordination with the Outpatient Treatment Team

during each Treatment Plan review and update.

b. Assessment of progress toward treatment goals and continued display of risk and functional impairment.

c. Treatment interventions, frequency, crisis and safety planning, and targeted discharge adjusted accordingly to support the need for continued stay.

d. Consider the following criteria when determining continued stay:

i. The Member continues to demonstrate significant risk of harm or functional impairment as a result of a Behavioral Health Condition; and

ii. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

F. DISCHARGE READINESS

1. The Division shall develop criteria for discharge from a BHRF that contains the elements listed in Section F.(2).

2. BHRF providers providing care and services to THP Members shall adhere to the following minimum discharge elements:

a. Discharge planning begins at the time of admission; and

b. Discharge readiness is assessed by the BHRF Staff in coordination with the Outpatient Treatment Team during each Treatment Plan review and update.

c. Consider the following criteria when determining discharge readiness:

i. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.

ii. Functional capacity is improved.

iii. Essential functions such as eating or hydrating necessary to sustain life have significantly improved or are able to be cared for in a less restrictive level of care.

iv. Member is able to self-monitor for health and safety, or a caregiver is available to provide monitoring in a less restrictive level of care.

v. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

G. ADMISSION, ASSESSMENT, TREATMENT AND DISCHARGE PLANNING

1. The Division shall require the AdSS to establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708, and as stated in Section G.(2).

2. BHRF providers shall adhere to the following admission, assessment, treatment, and discharge planning requirements:

   a. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a Member is completed before treatment is initiated and within 48 hours of admission.

   b. The Outpatient Treatment Team is included in the development of the Treatment Plan within 48 hours of admission.

   c. BHRF documentation reflects:

      i. All treatment services provided to the Member;

      ii. Each activity documented in a separate,

individualized medical record, including the date, time, and behavioral health professional conducting treatment activity;

iii. Which Treatment Plan goals are being achieved;

iv. Progress toward desired treatment goals; and

v. Frequency, length, and type of each treatment service or session.

d. BHRF Staff coordinates care with the Outpatient Treatment Team throughout the admission, assessment, treatment, and discharge process.

e. The Treatment Plan connects back to the Member's Service Plan.

f. A Secure BHRF Treatment Plan aligns with the court order.

g. A discharge plan is created during development of the initial Treatment Plan and reviewed at each review thereafter and updated accordingly.

h. A discharge plan documents the following:

i. Clinical status for discharge;

ii. The Responsible Person and Outpatient Treatment Team understands the follow-up treatment, Crisis and Safety Plan; and

iii. Coordination of care and transition planning are in process.

i. The BHRF Staff and Outpatient Treatment Team meet to review and modify the Treatment Plan at least once a month until discharge.

j. A Treatment Plan may be completed by a Behavioral Health Professional or by a Behavioral Health Technician with oversight and signature by a Behavioral Health Professional within 24 hours.

k. Implementation of a system to document and report on timeliness of the Behavioral Health Professional signature/review when the Treatment Plan is completed by a Behavioral Health Technician.

l. The BHRF provider has a process to actively engage the family and Responsible Person, or other designated

individuals, in the treatment planning process as appropriate.

m. Clinical practices, as applicable to services offered and populations served, demonstrate adherence to best practices for treating the following specialized service needs:

i. Cognitive/intellectual disability;

ii. Cognitive disability with comorbid Behavioral Health Condition;

iii. Older adults and co-occurring disorders; and

iv. Comorbid physical and Behavioral Health Condition.

n. Services deemed medically necessary through the assessment or Outpatient Treatment Team and not offered at the BHRF are documented in the Member's Service Plan with a description of the need, identified goals, and identification of providers who will be meeting the need.

3. The BHRF shall make the following services available and provided by the BHRF, and cannot be billed separately unless

otherwise noted below:

a. Counseling and therapy (group or individual):

Behavioral Health Counseling and Therapy shall not be billed on the same day as BHRF services unless specialized behavioral health counseling and therapy have been identified in the Service Plan as a specific Member need that cannot otherwise be met as required within the BHRF setting.

b. Skills Training and Development:

i. Independent Living Skills,

ii. Community Reintegration Skill Building, and

iii. Social Communication Skills.

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services:

i. Symptom management;

ii. Health and wellness education;

iii. Medication education and self-administration skills;

iv. Relapse prevention;

v. Psychoeducation services and ongoing support to

maintain employment and vocational skills, educational needs assessment and skill building;

vi. Treatment for a substance use disorder; and

vii. Personal care services.

H. BHRF AND MEDICATION ASSISTED TREATMENT

BHRF providers shall have written policies and procedures to ensure Members on Medication Assisted Treatment are not excluded from admission and are able to receive Medication Assisted Treatment to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018. First Special Session.

I. BHRF WITH PERSONAL CARE SERVICE LICENSE

1. BHRFs providing personal care services shall be licensed by the Arizona Department of Health Services to provide those personal care services and offered in accordance with A.A.C. R9-10-702 and A.A.C. R9-10-715.
2. BHRFs shall ensure that all identified needs can be met in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E).

J. ADMINISTRATIVE SERVICES SUBCONTRACTOR MONITORING AND OVERSIGHT

1. The Division shall provide oversight and monitoring of compliance by Administrative Services Subcontractors serving Members enrolled in a DDD subcontracted health plan with respect to any contractual delegation of duties specific to this policy and as specified in AdSS Medical Policy 320-V using the following methods:

    a. Conduct a Second Level Review of each case in which a BHRF prior authorization request was denied by the AdSS.
    b. Complete annual operational reviews of compliance.
    c. Analyze deliverable reports and other data as required.
    d. Review Provider Network Development and Management Plans demonstrating network adequacy and plans to promote specialty services described in policy.
    e. Conduct oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.
    f. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies through Behavioral Health Clinical Chart Audits.

2. The Division may request to review additional documentation, if necessary.

SUPPLEMENTAL INFORMATION

Examples of Personal Care Services

- ACE wraps, arm and leg braces
- Administration of oxygen
- Application and care of orthotic devices
- Application and care of prosthetic devices
- Application of bandages and medical supports, including high elastic stockings
- ACE wraps, arm and leg braces
- Application of topical medications
- Assistance with ambulation
- Assistance with correct use of cane/crutches
- Bed baths
- Blood sugar monitoring, Accu-Check diabetic care

- Care of hearing aids
- Catheter care
- Denture care and brushing teeth
- Dressing member
- G-tube care
- Hair care, including shampooing
- Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
- Measuring and giving insulin, glucagon injection
- Measuring and recording blood pressure
- Non-sterile dressing change and wound care
- Ostomy and surrounding skin care
- Passive range of motion exercise
- Radial pulse monitoring
- Respiration monitoring
- Shaving
- Shower assistance using shower chair
- Skin and foot care
- Skin maintenance to prevent and treat bruises, injuries, pressure sores and infections. (Members with a stage 3 or 4 pressure sore are not to

be admitted to a BHRF pursuant to A.A.C. R9-10-715(3).

- Supervising self-feeding of members with swallowing deficiencies
- Use of chair lifts
- Use of pad lifts

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:57 MST)

Anthony Dekker, D.O.

320-W THERAPEUTIC FOSTER CARE FOR CHILDREN

REVISION DATE: 1/10/2024, 2/2/2022
EFFECTIVE DATE: March 24, 2021
REFERENCES: A.R.S. Title 14, Chapter 5, Article 2 or 3; A.R.S. §§ 8-451.01, 8-514.05, 36-3221, 36-3231 or 36-3281; A.A.C. R9-10-101; ACOM Policy 414

PURPOSE

To delineate the responsibilities of the Division of Developmental Disabilities (Division) staff, contracted service providers, and other persons involved in providing Therapeutic Foster Care (TFC) and services to eligible Division Members, including Members enrolled in the Division's Tribal Health Program.

Further, this policy establishes requirements for Division oversight and monitoring of duties delegated to Administrative Services Subcontractors (AdSS) as specified in contract and AdSS Medical Policy 320-W.

DEFINITIONS

1. "Agency Worker" means a Therapeutic Foster Care Agency Worker that meets the minimum qualifications at the level of Behavioral Health Technician with a minimum of one year of experience in a human

services field.

2. "AHCCCS" means the Arizona Health Care Cost Containment System.

3. "Arizona Department of Child Safety" means the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

   a. Investigate reports of abuse and neglect.

   b. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.

   c. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.

   d. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthening the family and provide prevention, intervention, and treatment services pursuant to A.R.S. Title 8, Chapter 4.

4. "Behavioral Health Professional" means:

   a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

      i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-10;

b. A psychiatrist as defined in A.R.S. § 36-501;

c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. § 32-2091;

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral health services.

5. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care institution's policies and procedures, and with clinical oversight by a Behavioral Health Professional, that if provided in a setting other than a health care institution would require the individual to be licensed as a behavioral health professional under A.R.S Title 32, Chapter 33.

6. "Caregiver" means an adult who is providing for the physical, emotional, and social needs of a child.

7. **"**Child and Family Team" means a defined group of individuals that includes the child and their family, a behavioral health provider, and any individuals important in the child's life that are identified and invited by the child and family to participate.

8. "Crisis Plan" means a written plan established by the Member that is designed to prevent or reduce the effects of a behavioral health crisis. This plan identifies what is or is not helpful in crisis prevention through the identification of contacts and resources, and actions to be taken by the Member, family, Responsible Person, parents, guardians, friends, or others.

9. "Immediate Jeopardy" means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a member.

10. "Service Plan" means a comprehensive written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination

activities and strategies to assist the Member in achieving an improved quality of life. The Service Plan is created and managed by the CFT. It is a dynamic document that is regularly updated to adequately match the strengths and needs of the Member and family.

11. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

12. "Respite Care" means short-term relief for primary caregivers.

13. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

14. "Telemedicine" means the practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the member.

15. "Therapeutic Foster Care" means a covered behavioral health service that provides daily behavioral interventions within a licensed family setting and is designed to maximize the Member's ability to live and participate in the community and to function independently, including

assistance in the self-administration of medication and any ancillary services indicated by the Member's comprehensive Service Plan, as appropriate.

16. "Therapeutic Foster Care Agency Provider" means a TFC Agency Provider credentialed by a Managed Care Organization to oversee professional TFC Family Providers and holds contracts with pertinent health plans or the Department of Child Safety to provide TFC services to children.

17. "Therapeutic Foster Care Family Provider" means specially trained adult(s) in a family unit licensed by the Department of Child Safety and endorsed to provide TFC services to children.

18. "Therapeutic Foster Care Treatment Plan" means a written plan that details the specific behavioral goals that the TFC Family and TFC Agency Providers will help the Member achieve during the Member's time in TFC. These TFC treatment goals are explicit, observable, attainable, tailored to the Member's strengths and needs, and align with the comprehensive Service Plan of the CFT. The TFC Treatment Plan outlines the steps the TFC Family and TFC Agency Providers will implement to help the Member attain the TFC treatment goals and successful discharge from TFC.

POLICY

A. THERAPEUTIC FOSTER CARE

1. The Division and TFC Agency Providers shall adhere to the following requirements:
    a. Programmatic support is available to the TFC Family Providers 24 hours per day, seven days per week.
    b. Care and services provided in TFC:
        i. Are based on a 24-hour day per diem rate;
        ii. Require prior and continued authorization; and
        iii. Do not include room and board.
    c. TFC services are provided for no more than three children in a professional foster home.
    d. Appropriate notification is sent to the primary care provider and behavioral health home agency or TRBHA, as applicable, upon admission to and discharge from TFC.
2. TFC Family Providers and TFC Agency Providers shall adhere to The Department of Child Safety (DCS) policies and procedures for children involved with DCS.

B. CRITERIA FOR ADMISSION

1. The Division shall develop medical necessity criteria for

admission to TFC, and submit to AHCCCS for approval, that contains the following elements:

a. Recommendation for TFC comes through the Child and Family Team (CFT) process.

b. Following an assessment by a licensed Behavioral Health Professional (BHP), the Member has been diagnosed with a behavioral health condition that reflects the symptoms and behaviors necessary to warrant a request for TFC.

c. There is evidence that the Member has had a disturbance of mood, thought, or behavior within the past 90 days that renders the Member incapable of independent or age-appropriate self-care or self-regulation as a result of the Behavioral Health Condition, and that this moderate functional or psychosocial impairment, per assessment by a BHP:

   i. Cannot be reasonably expected to improve in response to a less intensive level of care; and

   ii. Does not require or meet clinical criteria for a higher level of care; or

iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

d. At the time of admission, in collaboration with the CFT and other individuals as applicable, there are documented plans for discharge and transition that identifies:

i. Tentative living arrangement, and

ii. Recommendations for aftercare treatment based on treatment goals.

C. EXCLUSIONARY CRITERIA

1. The Division shall not allow admission to TFC to be used as a substitute for the following:

a. Detention or incarceration;

b. Ensuring community safety in an individual exhibiting primarily conduct disorder behaviors;

c. Providing safe housing, shelter, supervision, or permanency placement;

d. The Responsible Person's capacity or other agency's capacity to provide for the Member; or

e. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs; including situations when the Responsible Person is unwilling to participate in the less restrictive alternative.

D. EXPECTED TREATMENT OUTCOMES

1. TFC Agency Providers shall align treatment outcomes with:

   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100; and

   b. The Member's individualized physical, behavioral, and developmentally appropriate needs.

2. TFC Agency Providers shall ensure treatment goals for the Member's time in TFC are:

   a. Specific to the Member's behavioral health condition that warranted treatment;

   b. Measurable and achievable;

c. Cannot be met in a less restrictive environment;

d. Based on the Member's unique needs;

e. Include input from the Member's family, Responsible Person, and other designated representatives where applicable; and

f. Support the Member's improved or sustained functioning and integration into the community.

3. TFC Agency Providers shall ensure active treatment with the services available at this level of care can reasonably be expected to:

a. Improve the Member's condition in order to achieve discharge from TFC at the earliest possible time; and

b. Facilitate the Member's return to primarily outpatient care in a non-therapeutic, non-licensed setting.

E. CRITERIA FOR CONTINUED STAY

1. The Division shall develop medical necessity criteria for continued stay, and submit to AHCCCS for approval, that contains the following elements:

a. The Member continues to meet the diagnostic threshold for

the behavioral health condition that warranted admission to TFC.

b. It can reasonably be expected that continued treatment will improve the Member's condition to the point that TFC will no longer be needed.

c. The CFT is meeting at least monthly to review progress and revise the TFC Treatment Plan and Service Plan to respond to any lack of progress.

d. The transitioning Caregiver after discharge has been identified and is actively involved in the Member's care and treatment, if applicable.

e. The Member continues to demonstrate moderate functional or psychosocial impairment within the past 90 days as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or age-appropriate self-care or self-regulation.

f. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors that were identified as reasons for admission to TFC and treatment is empowering the Member to gain skills to successfully function in the

community.

F. CRITERIA FOR DISCHARGE

1. The Division shall develop medical necessity criteria for discharge from TFC, and submit to AHCCCS for approval, that contains the following elements:

   a. Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.

   b. The Member's functional capacity is improved and the Member can be safely cared for in a less restrictive level of care.

   c. The Member can participate in age-appropriate self-monitoring and follow-up services or a Caregiver is available to provide monitoring in a less restrictive level of care.

   d. Appropriate services, providers, and supports are available to meet the Member's current behavioral health needs at a less restrictive level of care.

   e. There is no evidence to indicate that continued treatment in TFC would improve the Member's clinical outcome.

f. There is potential risk that continued stay in TFC may precipitate regression or decompensation of the Member's condition.

g. A current clinical assessment of the Member's symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in a TFC setting is no longer adequate to provide for the safety and treatment.

G. DISCHARGE PLANNING PROGRAM REQUIREMENTS

1. The TFC Agency Provider shall adhere to the following discharge planning program requirements:
   a. Discharge planning details are included in the TFC Treatment Plan, updated monthly, and align with the Service Plan.
   b. Discharge plans are completed using the approved standardized criteria.
   c. Discharge plans include identification of and consistent work with Responsible Persons, if applicable.
   d. The TFC team continues to plan for discharge as soon as an appropriate lower level of community-based care is

identified.

e. Successful discharge planning includes engagement of the receiving caregiver to participate in transitionary visits.

f. The TFC team assesses the needs of the receiving caregiver and provides the appropriate coaching and mentorship.

2. The CFT shall review and approve the discharge plans to ensure successful implementation of discharge planning details such that sustainable transition into a less restrictive setting is possible.

3. If a decision is made to move the Member to a higher level of care, the TFC Agency Provider shall work in collaboration with the TFC Family Provider and CFT to make the transition as seamless as possible.

H. TREATMENT PLANNING PROGRAM REQUIREMENTS

1. The TFC Provider Agency shall ensure the TFC Treatment Plan includes:

a. Development in conjunction with the CFT;

b. Strategies to address TFC Family Provider needs and

successful transition for the Member to begin service with the TFC Family Provider, including pre-service visits, when appropriate, as well as respite planning;

c. Complementing and not conflicting with the Service Plan and other defined treatments, and reference to the Member's:

i. Current physical, emotional, behavioral health, and developmental needs;

ii. Current educational placement and needs;

iii. Current medical treatment;

iv. Current behavioral treatment through other providers; and

v. Current prescribed medications.

d. Updating Member's current Crisis Plan in alignment with the TFC setting;

e. Addressing safety, social and emotional well-being, discharge criteria, acknowledgement of Member's permanency objectives and post-discharge services; and

f. Short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the Service Plan.

g. When age and developmentally appropriate, youth and biological family, kinship family, and adoptive family participation in development of the TFC Treatment Plan is required;

h. Specific elements that build on the Member's strengths, while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement; and

i. Specifics to coordinate with natural supports and informal networks as a part of treatment.

j. If the TFC Treatment Plan includes co-parenting engagement with the Member's Caregiver, development of specific goals to prepare the receiving Caregiver and successfully transition the Member to the new placement;

k. Plans for engagement of the Member's biological family,

kinship family, adoptive family, and or transition foster family, and other natural supports that can support the Member during TFC placement and after transition;

l. Respite planning;

m. Review by:

i. The TFC Family Provider and TFC Agency Provider at each home visit;

ii. The TFC Agency Provider and clinical supervisor at each staffing; and

iii. The TFC Agency Provider and CFT at each revision or at minimum quarterly.

n. Documentation of the TFC Treatment Plan which is kept by the TFC Family Provider and the TFC Agency Provider and shared with the CFT.

I. THERAPEUTIC FOSTER CARE ROLES, RESPONSIBILITIES AND QUALIFICATIONS

1. TFC Agency Providers shall be credentialed through the Division Administrative Services Subcontractors.

2. The TFC Agency Provider shall:

a. Ensure TFC Family Providers comply with all applicable state and local licensing requirements, including application, training, life safety inspections, and administrative requirements.

b. Ensure submission of deliverables.

c. Conduct one home visit per week during the initial six weeks of placement; these visits may be in person or Telemedicine.

d. Conduct a minimum of two home visits per month for continued stay beyond the initial six weeks of placement, with supporting documentation of each visit that includes:

i. Review of the TFC Treatment Plan with the TFC Family Provider;

ii. Review case files and required documentation; and

iii. Check medical records and medication logs.

e. Complete all AHCCCS required group biller requirements.

f. Conduct TFC Family Provider recruitment to maintain and

increase the number of providers that can meet the needs of Members receiving TFC services.

g. Conduct ongoing training per state licensing rules that develops the skills of TFC Family Providers to enable them to meet the needs of Members.

3. The TFC Agency Provider shall have staff to operate resource teams to support the TFC Family Provider as follows:

a. Beginning at the level of the Agency Worker, extending to the clinical supervisor;

b. Provide oversight by one or more independently licensed BHPs;

c. Work in concert, applying the specialized skills and knowledge for service planning, training, and support of direct service providers and the CFT; and

d. Each member of the team shall have in-depth familiarity with the strengths and needs of the TFC Family Provider in order to be effective resources in the provision of care, developing training plans, and assisting in matching Members to service environments.

4. The TFC Agency Provider shall have a documented agency crisis response policy that specifies:

    a. Supervisor's availability and the use of crisis response provider to augment hours of availability;

    b. The TFC Agency Provider fulfilling the role of first-line support for the TFC Family Provider and Member during times of crisis;

    c. Access to a TFC Agency Provider or appropriate agency staff available 24 hours a day, seven days a week; and

    d. Escalation to the appropriate TFC Agency Provider's clinical leadership is available at all times.

5. The TFC Agency Provider shall coordinate the TFC Treatment Plan with the Service Plan and incorporate the TFC Family Provider's participation in CFT meetings.

6. The TFC Agency Provider shall support the TFC Family Provider through clinical supervision available upon request or as the TFC Agency Worker that identifies needs, including:

    a. Provide training and specific skill building to enhance the

family's ability to stabilize behaviors and intervene as challenges arise;

b. Facilitate respite;

c. Attend all CFT, court, and professional meetings with or on behalf of the family; and

d. Contact between the TFC Family Provider and other caregivers in preparation for discharge.

7. The TFC Agency Provider shall ensure the following documentation, assessments, and records are updated and available:

a. Current TFC Treatment Plan;

b. Current Service Plan;

c. Crisis Plan;

d. Discharge plan;

e. Social history information;

f. Previous and current (within a year of referral date) behavioral health annual assessments, psychiatric

evaluations, psychological evaluations;

g. School and educational information;

h. Medical information,

i. Previous placement history and outcomes; and

j. Member and family strengths and needs, including skills, interests, talents, and other assists.

8. The TFC Agency Worker shall:

a. Be qualified, at minimum, at the level of Behavioral Health Technician with a minimum one year of experience in a human services field.

b. Be supervised by staff that possess a master's degree in a behavioral health field, and licensed in the state of Arizona, with a minimum two years of experience in a human services field.

c. Be the primary agency representative at the CFT meetings who shall:

i. Be present to review the Service Plan,

ii. Document progress to those plans,

iii. Support the CFT,

iv. Support the TFC Family Provider, and

v. Participate in the CFT meetings.

d. Lead the development of the TFC Treatment Plan with the TFC Family Provider and obtain clinical supervisor review.

e. Ensure the TFC Family Provider completes full and accurate clinical documentation of interventions on the TFC Treatment Plan to demonstrate progress toward meeting treatment needs is fully captured and provides an accurate record of case progress.

f. Ensure the TFC Treatment Plan is shared with the behavioral health agency and other treating providers or individuals, as applicable, as part of the Member's Service Plan to assure care coordination.

g. Monitor the number of Members assigned to a single Agency Worker.

i. The preferred maximum number of Members

assigned to a single Agency Worker is 10 members.

ii. The supervisor may lower the number of assigned Members to an Agency Worker if additional time is needed for one or more assigned families/members for oversight and support.

h. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider a minimum of once a week for the first six weeks of placement.

i. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider every other week or as needed for the remainder of the treatment, with one visit per month with the TFC Member to assess physical, emotional, and behavioral health needs are being met.

j. Encourage coordination, collaboration, and advocacy with the educational system to support the TFC Family Provider and Member in meeting treatment and educational goals.

J. TFC AGENCY PROVIDER SUPERVISION REQUIREMENTS

1. The TFC Agency Provider shall ensure the following supervision requirements are met:

a. Clinical Supervision requires behavioral professional or higher, with a graduate degree in a human services field, and licensed with a minimum two years of experience:

   i. Clinical supervision of TFC Agency staff that directly supports TFC Family Providers is completed by a qualified clinical professional through regular direct clinical supervision.

   ii. An Agency may employ a shared supervision model where administrative supervision is conducted by a non-clinical professional.

b. Administrative supervision requires a master's degree in a human services field and a minimum two years of experience.

c. Treatment planning for TFC Agency Providers is overseen by a qualified clinical professional as specified below:

   i. The TFC Agency Provider shall define and document minimum frequency of TFC Treatment Plan reviews no less than once per quarter.

   ii. The clinical supervisor shall have direct in-person or

Telemedicine contact with the TFC Family Provider at least once per month;

iii. The clinical supervisor is part of the treatment team and shall be active in the case review and not solely independently reviewing the TFC Treatment Plan.

iv. The clinical supervisor shall participate in the CFT meetings on an as-needed basis depending on the progress of the TFC Treatment Plan.

K. TFC FAMILY PROVIDER REQUIREMENTS

1. TFC Family Providers shall meet the following requirements:

   a. Have at least one year of experience as an active licensed foster home working directly with Members or professional experience working directly with Members that have behavioral health issues or developmental disabilities or both.

   b. Adhere to AHCCCS registration and requirements as an AHCCCS registered provider.

   c. Complete all TFC Agency Provider training requirements

and evaluations in prepatration to provide TFC services effectively and safely to members and their families, as well as any ongoing training requirements identified by the TFC Agency Provider in collaboration with the CFT.

d. Abide by all licensing regulations as outlined in applicable state and federal statutes for family foster parent licensing requirements, therapeutic level of licensure.

e. Provide basic parenting functions consistent with providing food, clothing, shelter, educational support, medical needs, transportation; teaching daily living skills, social skills; developing community activities; and supporting cultural, spiritual and religious beliefs.

f. Provide behavioral interventions associated with anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and intervention, and other behavioral interventions as needed, that aid the Member in making progress on TFC Treatment Plan goals.

g. Provide a family environment with opportunities for:

i. Familial and social interactions and activities;

ii. Use of behavioral interventions;

iii. Development of age-appropriate living and self-sufficiency skills; and

iv. Integration into a family and community-based setting.

h. Meet the individualized needs of the Member in their home as defined in the Member's TFC Treatment Plan.

i. Be available to care for the Member 24 hours per day, seven days a week, for the entire duration that the Member is receiving out-of-home treatment services, including times the Member is with respite caregivers.

j. Ensure that the Member's needs are met when the Member is in Respite Care with other TFC Family Providers.

k. Participate in planning processes such as CFTs, TFC discharge planning, and individualized education programs.

l. Keep the following documentation per requirements of the

TFC Agency Provider:

i. Record behavioral health symptoms,

ii. Incident reports,

iii. Interventions utilized,

iv. Progress toward the TFC Treatment Plan goals, and

v. Discharge plan.

m. Assist the Member in maintaining contact with their family and natural supports.

n. Assist in meeting the Member's permanency planning or TFC discharge planning goals.

o. Advocate for the Member in order to achieve TFC Treatment Plan goals and to ensure timely access to educational, vocational, medical, or other indicated services.

p. Provide medication management consistent with AHCCCS guidelines for Members in out-of-home care.

q. Report allegations of abuse, neglect, and misconduct

toward Members as required by state and federal law.

r. Maintain confidentiality as required by state and federal law.

2. Any request to move a Member from placement prior to successful completion of the TFC Treatment Plan shall be made through the CFT, and written notice provided following contractual time frames, with the only exception being Immediate Jeopardy.

3. TFC Family Providers shall follow the Crisis Plan and work to preserve the placement, including consultation with the CFT for consideration of additional in-home supports and services as appropriate and necessary to support the Member and family.

4. The TFC Family Provider shall utilize the Crisis Plan and accept agency worker and supervisor support, including the use of respite, to maintain the placement until an emergency CFT meeting is convened, services implemented, and the placement is preserved.

5. If a TFC placement cannot be preserved, the TFC Agency Provider shall support the Member and TFC Family Provider until

a transition is identified.

L. DIVISION OVERSIGHT AND MONITORING OF AdSS

1. The Division shall use the following methods to ensure the AdSS are in compliance with AdSS Medical Policy 320-W:

   a. Complete annual operational reviews of compliance.

   b. Analyze deliverable reports or other data as required, including Provider Network Development and Management Plans demonstrating network adequacy and plans to promote specialty services described in this policy.

   c. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.

   d. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies through Behavioral Health Chart Reviews.

SUPPLEMENTAL INFORMATION

1. For aftercare planning for DCS involved members, the TFC Family Provider may be the discharge placement. In such cases where the TFC Family Provider is the discharge placement, DCS foster care rates, policies, and procedures apply. Licensing agencies shall coordinate these actions through the CFT and DCS as they are not governed by this Policy.

2. Ongoing appropriate and approved relationship and communication with the TFC family provider after discharge is encouraged. This is determined with Responsible Person approval and in the best interest of the member.

3. TFC Family Providers are licensed through DCS and do not require credentialing by the AdSS.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:50 MST)
Anthony Dekker, D.O.

320-X ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES

REVISION DATE: February 2, 2022
EFFECTIVE DATE: March 24, 2021

PURPOSE

This Policy establishes requirements for the provision of care and services to Division members in Adult Behavioral Health Therapeutic Homes. The Division covers Adult Behavioral Health Therapeutic Home services for members eligible for ALTCS regardless of the health plan they choose. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for Division members enrolled in the Tribal Health Program (THP). See AdSS Policy 320-X for responsibilities of the AdSS providing Adult Behavioral Health Therapeutic Home services.

DEFINITIONS

Adult Behavioral Health Therapeutic Home (ABHTH) - A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self- administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's treatment plan, as appropriate.

Adult Recovery Team (ART) – A group of individuals that follows the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems. Working in collaboration and are actively involved in an individual's assessment, service planning, and service delivery.

Assessment – An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101

Behavioral Health Professional (BHP) –

A. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   1. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

   2. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,

B. A psychiatrist as defined in A.R.S. §36-501,

C. A psychologist as defined in A.R.S. §32-2061,

D. A physician,

E. A behavior analyst as defined in A.R.S. §32-2091, or

F. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

G. A registered nurse with:

1. A psychiatric-mental health nursing certification, or

2. One year of experience providing behavioral health services.

Collaborating Health Care Institution (CHI) – A health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:

A. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and

B. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan. A.A.C. R9-10-101 (51.)

Designated Representative – An individual acting on behalf of the member with the written consent of the member or member's legal guardian. As used in this policy the designated representative is distinct and separate from the health care decision maker.

Health Care Decision Maker – An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§8-514.05, 36-3221, 36-3231 or 36-3281.

Provider – Any individual or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

Service Plan – A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Treatment Plan – For the purpose of this policy, treatment plan is used to describe a complete written description of all services to be provided by the ABHTH based on the intake assessments and service plan.

POLICY

An Adult Behavioral Health Therapeutic Home (ABHTH) is a residential setting in the community that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's service plan and/or treatment plan as appropriate.

Programmatic support is available to the ABHTH providers 24 hours per day, seven days per week by the collaborating health care institution (CHI). Care and services provided in an ABHTH are based on a per diem rate (24-hour day) and do not include room and board (Arizona State Plan for Medicaid).

ABHTH providers shall adhere to this policy as well as procedure requirements as specified in A.A.C. R9-10-1801 et. seq., and the Arizona State Plan for Medicaid.

A. Criteria for Admission

The Division shall develop admission criteria for medical necessity which, at a minimum, includes the below elements. The Division shall submit admission criteria to AHCCCS for approval and publish the approved criteria on the Division's website.

1. Criteria for Admission:

   a. The recommendation for ABHTH shall come through the Adult Recovery Team (ART) process,

   b. Following an assessment by a licensed behavioral health professional (BHP), the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for ABHTH,

   c. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per assessment by a BHP:

      i. Cannot be reasonably expected to improve in response to a less intensive level of care, and

      ii. Does not require or meet clinical criteria for a higher level of care, or

      iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

   d. At time of admission to an ABHTH, in participation with the health care decision maker and all relevant stakeholders, there is a documented plan for discharge which includes:

      i. Tentative disposition/living arrangement identified, and

      ii. Recommendations for aftercare treatment based upon treatment goals.

B. Exclusionary Criteria

Admission to an ABHTH shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors.

3. As a means of providing safe housing, shelter, supervision or permanent placement.

   A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/health care decision maker is unwilling to participate in the less restrictive alternative.

C. Expected Treatment Outcomes

1. Treatment outcomes shall align with:

   a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM, Policy 100, and

   b. The member's individualized physical, behavioral, and developmentally appropriate needs.

2. Treatment goals for members placed in an ABHTH shall be:

   a. Specific to the member's behavioral health condition that warranted treatment,

   b. Measurable and achievable,

   c. Unable to be met in a less restrictive environment,

   d. Based on the member's unique needs,

   e. Inclusive of input from the member's family/health care decision maker and designated representative's choices where applicable, and

   f. Supportive of the member's improved or sustained functioning and integration into the community.

3. Active treatment with the services available at this level of care can reasonably be expected to:

   a. Improve the member's condition in order to achieve discharge from the ABHTH at the earliest possible time, and

   b. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

D. Adult Behavioral Health Therapeutic Homes Treatment Planning

The ABHTH treatment plan shall be developed by the CHI in collaboration with the ABHTH provider and the ART within the first 30 days of placement:

1. The treatment plan shall:

   a. Describe strategies to address ABHTH provider needs and successful transition for the member to begin service with ABHTH provider, including pre-service visits when appropriate,

   b. Compliment and not conflict with the ART service plan and other defined treatments, and shall also include reference to the member's:

      i. Current physical, emotional, behavioral health and developmental needs,

      ii. Current educational placement and needs,

      iii. Current medical treatment,

      iv. Current behavioral health treatment through other providers, and

      v. Current prescribed medications.

   c. Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,

   d. Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ART service plan,

   e. Clearly identify responsible individuals from treatment team to implement each aspect of the ABHTH treatment plan and the timing of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH treatment plan,

   f. Include specific elements that build on the members' strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,

   g. Include specifics to coordinate with natural supports and informal networks as a part of treatment,

   h. Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,

   i. Be reviewed by the ABHTH provider and CHI at every home visit,

   j. Be reviewed by the CHI clinical supervisor at each staffing,

   k. Be revised as appropriate or quarterly at minimum, and

   l. Include documentation of the ABHTH treatment plan which shall be kept by the ABHTH Provider and CHI.

2. The Division and providers shall ensure that members/health care decision maker and designated representatives receive a copy of the treatment plan and any updated treatment plans.

E. Criteria for Continued Stay

The Division shall develop medically necessary criteria for continued stay which, at a minimum, include the below elements. The Division shall submit continued stay criteria to AHCCCS for approval and publish the approved criteria on the Division's website.

1. All of the following shall be met:

   a. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH,

   b. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or appropriate self-care or self-regulation,

   c. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community,

   d. There is an expectation that continued treatment at the ABHTH shall improve the member's condition so that this type of service shall no longer be needed, and

      The ART is meeting at least monthly to review progress and have revised the treatment plan and/or Service Plan to respond to any lack of progress.

F. Adult Behavioral Health Therapeutic Homes Discharge Planning

A comprehensive discharge plan shall be created during the development of the initial treatment plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:

1. Clinical status for discharge.

2. Follow-up treatment, crisis, and safety plan.

3. Coordination of care and transition planning are in process when appropriate.

G. Criteria for Discharge

The Division shall develop medical necessity criteria for discharge from an ABHTH setting which, at a minimum, includes the below elements. The Division shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the Division's website.

1. Sufficient symptom or behavior relief is achieved as evidenced by completion of the ABHTH treatment goals.

2. The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care.

3. The member can participate in needed monitoring and follow-up services or a Provider is available to provide monitoring in a less restrictive level of care.

4. Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.

5. There is no evidence to indicate that continued treatment in an ABHTH would improve member's clinical outcome.

6. There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

H. The Division's Reporting Requirements

1. The Division shall monitor and report ABHTH bed utilization as specified in ACOM Policy 415, Attachment G, or as requested by AHCCCS.

2. The Division shall report medical necessity criteria for admission, continued stay, and discharge for prior approval as specified in Contract.

320-Z MEMBERS ON CONDITIONAL RELEASE

EFFECTIVE DATE: August 30, 2023
REFERENCES: A.R.S. § 12-136; A.R.S. § 13- 3991; A.R.S. §§ 13-3994 through 13-4000; APMPM 320-U; AMPM 320-Z; TRBHA Intergovernmental Agreement (IGA).

PURPOSE

This Policy establishes requirements for the Care Management and oversight of individuals who have been granted conditional release from the Arizona State Hospital (ASH) by the Superior Court.

DEFINITIONS

1. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

2. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

3. "Conditional Release Plan" or "CRP" means a supervised treatment plan ordered by the Superior Court in conjunction with the State mental health facility and behavioral health community providers which specifies the conditions of a Member's release.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, peer-and-recovery support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. For purposes of this Policy, for fee-for-service populations, the term Treatment Plan may be used interchangeably with the term Service Plan.

6. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to

promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. CARE MANAGEMENT

1. The Division shall not delegate the Superior Court Contractor Care Management functions to the Administrative Services Subcontractors (AdSS) for Members who have been granted conditional release from the Arizona State Hospital (ASH).

2. The Division's HCS Complex Care team shall be responsible for:
   a. Acting as the single key point of contact who is responsible for collaboration with the Arizona State Hospital (ASH) and the Superior Court;
   b. Coordinating with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge;
   c. Participating in the development and implementation of the

CRP;

d. Participating in the modification of an existing or the development of a new Service Plan that complies with the CRP;

e. Ensuring coordination of care with the Member's treatment team, Tribal Regional Behavioral Health Authority (TRBHA) assigned Support Coordinator, and providers of both physical and behavioral health services to implement the Service Plan and the CRP;

f. Providing Member outreach and engagement at least once per month to assist the Superior Court in evaluating compliance with the approved CRP;

g. Attending outpatient staffing at least once per month either telephonically or face-to-face;

h. Providing routine review of administrative and clinical activities, submitting the Conditional Release Monthly Monitoring Report, and confirmation of delivery of

reporting to the Superior Court, and ASH;

2. The Division shall confirm immediate notification was completed by the outpatient provider to the Superior Court and ASH if a Member violates any term of his or her CRP, psychiatric decompensation, or use of alcohol, illegal substances or prescription medications not prescribed to the Member, and provide a copy to AHCCCS.

3. The Division, in conjunction with ASH and supervision of the courts shall engage the outpatient provider in care coordination as necessary, when there is any necessary revocation to inpatient or secured status for patients on full conditional release.

4. The Division shall provide outpatient provider monitoring to include:

   a. Monitoring activities and services provided to assure Member compliance with Conditional Release Plan (CRP); and

   b. Ensuring behavioral health provider completion and

notifications to the Superior Court, AHCCCS, and ASH including:

i. Mental health reports,

ii. Monitoring Conditional Release Monthly Monitoring Report, for Members on conditional release, and

iii. Providing additional documentation at the request of AHCCCS, ASH, or the Superior Court.

B. DIVISION RESPONSIBILITIES

1. The Division shall:

   a. Ensure AdSS provides training to outpatient providers serving Members on conditional release and ensure outpatient providers demonstrate understanding of A.R.S. § 13-3991 and A.R.S. §§ 13-3994 through 13- 4000, duties of outpatient providers; and

   b. Establish relationships with the Superior Court and ASH to support streamlined communication and collaboration between the Division, outpatient treatment team, ASH, and the Superior Court.

2. The Division Behavioral Health Complex Care Specialist shall coordinate with the Support Coordinator and care manager, as needed, for Members on Conditional Release from the Arizona State Hospital (ASH) consistent with the CRP issued by the Superior Court to facilitate discharge.

3. The Division shall monitor the status and outcomes of Members subject to a Conditional Release issued by the Superior Court and AHCCCS, including through the Conditional Release Monthly Monitoring Report as directed by the Contractor Chart of Deliverables

4. The Division shall follow all obligations, including those stated in this section, applicable to it as set forth as specified in A.R.S. § 13-3994.

C. FOR MEMBERS ENROLLED WITH TRIBAL HEALTH PLAN (THP) OR TRBHA

1. The Support Coordinator shall provide case management for THP members in collaboration with TRBHA or behavioral health case manager, as applicable.

2. The Support Coordinator shall notify the case managers of the requirement to directly coordinate with ASH and the Superior Court if case management is being provided by a FFS provider.

3. Support Coordination shall refer FFS behavioral health providers to AMPM 320-Z for requirements.

4. The Division shall refer to AMPM 320-U Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment for additional information regarding the recognition of tribal court orders.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:03 PDT)
Anthony Dekker, D.O.

330 CHILDREN'S REHABILITATIVE SERVICES

REVISION DATE: 10/1/2018, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S Title 32; A.A.C. R9-22-1301, A.A.C. R9-22-1303

Members eligible for Arizona Long Term Care System (ALTCS) with certain diagnoses may be eligible to receive Children Rehabilitative Services (CRS) at one the multi-specialty/interdisciplinary care settings, in addition to community based providers in independent offices. The respective Administrative Service Subcontractors (AdSS) provides covered medical, surgical, or therapy modalities for CRS enrolled members. The AdSS provides CRS covered services for CRS qualifying condition and conditions arising as a result of or related to the CRS qualifying condition when medically necessary. The AdSS does not cover routine, preventive, or other non-CRS related covered services. Members will receive acute care services through their Division acute health plan when being treated for a non-Children's Rehabilitative Services (CRS) diagnoses. Members who are 21 years of age and older are subject to all limitations and exclusions applicable to the adult population.

CRS medical services are in accordance with Arizona Administrative Code Title 9, Chapter 22, Article 2. Coverage limitations and exclusions for members 21 years of age and older apply.

The AdSS or authorized subcontractors provide medically necessary CRS services in both inpatient and outpatient settings, including contracted hospitals, multispecialty interdisciplinary clinics (MSICs), community-based field clinics, community based provider offices, behavioral health, and skilled nursing facilities.

Certain services may be available only in limited types of service settings or may be medically appropriate only for members with a particular clinical presentation. Services may require prior authorization from the AdSS and may require additional documentation to determine the medical necessity of the service requested for treating the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the eligibility process. DMS may also provide information received for purposes of eligibility determination for the CRS designation regarding care, services or procedures that may have been approved or authorized by the member's current health plan. The AdSS is responsible for ensuring that information provided by AHCCCS Division of Member Services is made available to the appropriate areas and staff within its organization who may need the information. The AdSS is responsible for appropriately transitioning members utilizing established transition processes. Members are permitted to opt out of, or refuse enrollment into, the CRS designation.

The AdSS provides services through an approach to service delivery that is family centered, coordinated and culturally competent, in a manner that considers the unique medical and behavioral holistic needs of the member.

CRS members may been seen for care and specialty services by the AdSS contracted network providers within the community that are qualified or trained in the care of the

member's condition. CRS members may also benefit from treatment in clinic-based multi-specialty/interdisciplinary care settings when active treatment is required, in addition to care and services provided by community based providers in independent offices. The AdSS also provides community based services including services provided in field clinics. When medically necessary services are not available in state, the AdSS is required to provide services out of state.

Covered benefits for CRS Partially Integrated members are the same as those provided by the Acute Contractors and the Behavioral Health Contractors including any necessary placement settings such as skilled nursing facilities, chemotherapy, hospice, transplant services, and behavioral health placement settings, as determined to be medically necessary and resulting from the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

Definitions

A. Active Treatment - a current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that last, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.

B. Chronic - expected to persist over an extended period of time.

C. CRS condition - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

D. CRS Fully Integrated - a coverage type which includes members who receive all services from the CRS AdSS including acute health, behavioral health and CRS-related services.

E. CRS Partially Integrated Acute - a coverage types which includes American Indian members who receive all acute health and CRS-related services from the CRS AdSS and who receive behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA).

F. CRS Partially Integrated Behavioral Health - a coverage type which includes DDD members who receive all behavioral health and CRS-related services from the primary program of enrollment.

G. CRS Only - a coverage type which includes members who receive all CRS-related services from the CRS AdSS, who receive acute health services from the from the primary program of enrollment, and DDD American Indian member who receive behavioral health services from the TRBHA.

H. CRS Provider - a person who is authorized by employment or written agreement with the AdSS to provide covered CRS services to a member or covered support services to a member or a member's family.

I. Field Clinic - a "clinic" consisting of single specialty health care providers who travel to health care delivery settings close to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

J. Functionally Limiting - a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a CRS provider. (A.A.C. R9-22-1303)

K. Medically Eligible - meeting the medical eligibility requirements of A.A.C. R9-22-1303.

L. Multi-Specialty Interdisciplinary Clinic (MSIC) - an established facility where specialists form multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

Medical Services

Medical services are provided in accordance with A.A.C. R9-22, Article 2. The Administrative Services Subcontractor is responsible for the following services:

A. Audiology Services

Audiology is a covered service as described in Division Medical Policy 310-A-Audiology, within certain limitations, to evaluate and rehabilitate members with hearing loss. For purposes of providing CRS, the following applies:

1. Audiologic Assessments must be consistent with accepted standards of audiologic practice.

2. Hearing Aid Fittings and Evaluations are covered as follows:

   a. Hearing aids

      i. The member may have their hearing aid reevaluated annually.

      ii. A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement due to the hearing aid being lost, broken, or non-functioning.

   b. Implantable bone conduction devices

   c. Cochlear implants. For further information, refer to Division Medical Policy 430, Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

B. Dental and Orthodontia Services

Dental and Orthodontia Services are covered services, with certain limitations as described in Division Medical Policy 431 Oral Health Care (EPSDT-Age Members). For purposes of providing CRS, the following applies:

1. Dental Services

Full ranges of dental services are covered for members eligible for CRS having at least one of the following:

a. Cleft lip and/or cleft palate

b. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis

c. A cardiac condition where the member is at risk for subacute bacterial endocarditis

d. Dental complications arising as a result of treatment for a CRS condition

e. Documented significant functional malocclusion

i. When the malocclusion is defined as functionally impairing in a member eligible for CRS with a craniofacial anomaly or

ii. When one of the following criteria is present:

(a) Masticatory and swallowing abnormalities that affect the nutritional status of the individual resulting in growth abnormalities

(b) Clinically significant respiratory problems, induced by the malocclusion, such as dynamic or static airway obstruction

(c) Serious speech impairment, determined by a speech therapist, that indicates the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by speech therapy alone.

2. Orthodontia Services

Medically necessary Orthodontia Services are covered for a member eligible for CRS with a diagnosis of cleft palate or documented significant functional malocclusion as described in B.1.a. and B.1.e. (above).

C. Diagnostic Testing and Laboratory Services

Medically necessary diagnostic testing and laboratory services are covered as described in Division Medical Policy 310. For purposes of providing CRS, the following applies:

Limitations

1. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options as described in Division Medical Policy 310, and when related to a CRS condition.

2. Follow-up laboratory evaluations for conditions unrelated to the CRS condition are excluded. The member must be referred to his or her primary care provider for follow-up care.

D. Durable Medical Equipment (DME)

Medically necessary DME is covered as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services). For purposes of providing CRS, the following applies:

- Durable medical equipment for rehabilitative care
- Equipment repairs
- Equipment modifications.

1. Exclusion and Limitations of Durable Medical Equipment Services

Note: Refer to D.4 and D.5 (below) for specific information related to wheelchair and ambulation devices.

a. Members are eligible for equipment only when ordered by a CRS-contracted provider and/or authorized by the AdSS.

b. Cranial modeling bands are excluded except for members who are 24 months of age or younger who have undergone CRS-approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional surgery.

2. Equipment Maintenance for Durable Medical Equipment Services

Covered services include equipment modifications necessary due to the member's growth or due to a change in the member's orthopedic or health needs. The request for modification must come from a CRS contracted provider.

3. Equipment Replacement or Repair for Durable Medical Equipment Services

The AdSS must ensure that Durable Medical Equipment found to be unsatisfactory due to imperfect or faulty construction is corrected, adjusted, or replaced.

4. Wheelchairs and Ambulation Devices

a. Routine or custom wheelchairs and/or ambulation assistive devices (crutches, canes, and walkers) are provided for members eligible to receive CRS, based on medical necessity.

b. Medically necessary equipment modifications and replacement are covered.

c. Custom fit standards and parapodiums are covered for members eligible to receive CRS with spinal cord defects who have walking potential.

d. Trays for wheelchairs are provided when documentation indicates that the need is directly related to improvement in functional skill.

e. The member and/or their family must demonstrate that they can safely use all equipment provided to the member, as verified and documented by the treating provider or wheel chair fitting provider. Practical and functional use of the equipment must be documented in the CRS medical record.

5. Limitations and Exclusions Related to Wheelchairs and Ambulation Devices

a. Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.

b. Physical or structural modifications to a home are excluded.

c. After initial delivery, care and transportation of the equipment, including vehicle modifications, is the responsibility of the member and/or the member's guardian.

d. Repairs or maintenance to equipment that was not provided to the member by the AdSS are provided, when a CRS provider has determined the equipment to be safe and appropriate.

E. High Frequency Chest Wall Oscillation Therapy

High Frequency Chest Wall Oscillation (HFCWO) therapy is a covered service, for members under 21 years of age.

1. HFCWO is covered when there is:

a. A diagnosis of cystic fibrosis

b. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance

c. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD)

d. Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily chest physiotherapy

e. Member is two years of age or older, or has a documented chest size of 20 inches or greater, whichever comes first

f. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:

i. Promotes independent self-care for the individual

ii. Allows independent living or university or college attendance for the individual

iii. Provides stabilization in single adults or emancipated individuals without able partners to assist with Chest Physical Therapy (CPT), or

iv. Severe end-stage lung disease requiring complex or frequent CPT.

g. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy

h. Coordination prior to implementation of HFCWO therapy for long-term use between the CRS provider office/clinic or DDD Contractor, or other payer source has occurred.

2. Discontinuation Criteria for HFCWO

HFCWO services will be discontinued if there is:

1. Member and/or prescribing physician request, or

2. Patient treatment compliance at a rate of less than 50% usage, as prescribed in the medical treatment plan, that is verified at two and six months of use.

F. Home Health Care Services

Medically necessary home health care services, as described in Division Medical Policy 310-I Home Health Services. Home health care services include professional nurse visits, therapies, equipment, and medications. Home health

care services must be ordered by a CRS contracted provider. The home health care service is covered for a CRS member when the home health service is specifically for the treatment of a CRS or CRS-related condition.

G. Inpatient Services

The AdSS covers medically necessary inpatient services, as described in Division Medical Policy 310-K Hospital Inpatient Services. The hospitalization is covered for a member when the hospitalization is for the treatment of a CRS condition or a condition that is related to, or the result of, the CRS condition.

CRS requirements for admission and coverage for an inpatient acute care stay are as follows:

1. CRS authorized providers with admitting privileges can admit and treat CRS members for CRS qualifying conditions or those conditions related to, or the result of, a CRS condition. Providers must have a contract with the AdSS or receive an authorization from the AdSS. The admitting provider must obtain prior authorization from the AdSS for all non-emergency hospital CRS-related admissions.

2. Prior authorization is not required for an emergency service.

3. The primary reason for hospitalization must be related to, or the result of, the CRS condition.

H. Growth Hormone Therapy

Growth hormone therapy is only covered for members with panhypopituitarism.

I. Nutrition Services

CRS covers medically necessary nutritional services. For purposes of the CRS designation, nutrition services include screening, assessment, intervention, and monitoring of nutritional status. The AdSS must cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition or resulting from the CRS condition. The CRS designation covers nutritional supplements upon referral from CRS providers with consultation by a registered dietician.

Note: Covered services also include special formula to meet the nutritional needs of members with metabolic needs.

Limitations

1. A registered dietitian must provide nutrition services.

2. Total Parenteral Nutrition (TPN) for long-term nutrition is covered if medical necessity and is related to, or resulting from, the CRS condition.

J. Outpatient Services

The AdSS is responsible for outpatient services where the diagnosis is a CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

CRS outpatient services include:

1. Ambulatory/outpatient surgery

2. Outpatient diagnostic and laboratory services

3. Ancillary services: Laboratory, Radiology, Pharmacy Services, Medical Supplies, Blood, Blood Derivatives, Therapies, Ambulatory Surgeries

4. Clinic services

   a. CRS members may benefit from multi-specialty, interdisciplinary care teams, in addition to community-based providers. The AdSS shall make available these care teams throughout the state.

      Community-based field clinics are specialty clinics that are held periodically in outlying towns and communities in Arizona, or on Indian Reservations.

   b. CRS members may be seen by AdSS community based providers in independent offices for CRS qualifying conditions or conditions that are related to, or the result of, a CRS condition.

Limitations

The member's primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

K. Pharmaceutical Services

The AdSS covers medically necessary prescription medication and pharmacy services, as described in Division Medical Policy 310-V Prescription Medication and Pharmacy Services. Under the CRS designation, pharmaceuticals are covered when appropriate for the treatment of the CRS condition or a condition that is related to, or the result of, a CRS condition, when ordered by the CRS provider, and provided through a CRS contracted pharmacy. The AdSS is required to provide community-based pharmacy services.

Limitations

1. Pharmaceuticals or supplies that would normally be ordered by the primary care provider for the non-CRS covered condition(s) are not covered.

2. Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by the CRS designation.

L. Physical and Occupational Therapy Services

The Division covers medically necessary physical and occupational therapy services, as described in Division Medical Policies 310-K Hospital Inpatient Services and 310-X Rehabilitative Therapies. For purposes of the CRS designation, physical therapy and occupational therapy services are provided when the service is medically necessary and prescribed to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition. Limitations listed for members age 21 and older in AMPM Policy 310, Covered Services apply.

M. Physician Services

The Division covers medically necessary physician services, as described in Division Medical Policy 310-T Physician Services. For purposes of the CRS designation, physician services must be furnished by an AHCCCS registered, licensed physician and must be covered for members when rendered within the physician's scope of practice under A.R.S Title 32. The AdSS is responsible for contracting with physician specialists with expertise in pediatrics to provide CRS covered services.

Medically necessary physician services may be provided in an inpatient or outpatient setting.

N. Prosthetic and Orthotic Devices

The Division covers medically necessary prosthetic and orthotic services, as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment and Prosthetic Devices (Acute Care Services). Under the CRS designation, prosthetic and orthotic devices are provided when medically necessary to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition.

1. Maintenance and Replacement

a. The CRS designation covers prosthetic and orthotic modifications or repairs that are related to the CRS condition and medically necessary.

b. The CRS designation covers ocular prostheses and replacements when medically necessary and when related to a CRS condition.

c. Prior authorization is required for replacement of lost or stolen prosthetic and orthotic devices.

The CRS designation must provide or fabricate orthotic/prosthetic devices that assist CRS members in performing normal living activities and skills. Requirements include:

i. All orthotic/prosthetic devices must be constructed or fabricated using high quality products.

ii. All orthotics must be completed, modified or repaired, and

delivered to the CRS member within 15 working days of the provider's order.

iii. All prosthetics must be completed, modified or repaired, and delivered to the CRS member within 20 working days following the member's provider order.

iv. Orthotic/prosthetic repairs ordered by a CRS provider as urgent must be delivered within five working days.

v. Same day service must be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.

d. The CRS designation will assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device, except as required to accommodate a documented change in the member's physical size, functional level, or medical condition.

2. Limitations and Exclusions

a. Myoelectric prostheses are excluded.

b. Limitations for members age 21 and older apply as described in AMPM 310-JJ.

O. Psychology/Behavioral Health Services

For discussion of behavioral health services, please see AMPM Policy 310-B, Behavioral Health Services.

P. Second Opinions

The CRS designation covers second opinions by other CRS contracted physicians, when available. If not available, CRS will provide a second opinion by a contracted specialty provider able to treat the condition or a same specialty non-CRS contracted provider.

Q. Speech Therapy Services

The Division covers medically necessary speech therapy services, as described in AMPM Policy 310. Speech therapy services are provided by the CRS designation when the service is medically necessary and prescribed to treat the CRS diagnosed or a related condition. Limitation for members age 21 and older apply as per AMPM Policy 310, Covered Services.

R. Transplant Services

The CRS designation covers transplant services for CRS qualifying conditions or those conditions related to, or resulting from, the CRS condition.

S. Telemedicine

The Division covers telemedicine, as described in Division Medical Policy 320-I Telehealth and Telemedicine. The CRS designation covers telemedicine when it is related to the member's CRS condition. The purpose of telemedicine is to provide clinical and therapeutic services by means of telemedicine technology. This technology is used to deliver care and services directly to the member and to maximize the provider network.

T. Transportation

The Division covers medically necessary transportation services, as described in Division Medical Policy 310-BB Transportation. The CRS designation covers transportation for a member who is receiving services for a CRS condition or a CRS-related service.

U. Vision Services

The CRS designation covers vision services including examinations, eyeglasses, and/or contact lenses for the treatment of a CRS or CRS-related condition.

410 MATERNITY CARE SERVICES

REVISION DATE: 10/25/2023, 6/08/2022
EFFECTIVE DATE: August 5, 2021
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Exhibit F3, Contractor Chart of Deliverables

PURPOSE

This policy establishes requirements for the Division of Developmental Disabilities (Division) regarding Maternity Care Services.

DEFINITIONS

1. "Certified Nurse Midwife" or "CNM" means an individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, Postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

2. "Free Standing Birthing Centers" means an out-of-hospital, outpatient obstetric facility, licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to assist with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities are affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.
3. "High-Risk Pregnancy" means a pregnancy in which the birthing mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
4. "Licensed Midwife" or "LM" means an individual licensed by the Arizona Department of Health Services (ADHS) to provide Maternity Care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. Title 9, Chapter 16 This provider type does not

include Certified Nurse Midwives licensed by the Board of Nursing as a nurse Practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.

5. "Maternity Care" means identification of pregnancy, Prenatal Care, labor or delivery services, and Postpartum Care.
6. "Maternity Care Coordination" means the following Maternity Care related activities:
    a. Determining the member's medical or social needs through a risk assessment evaluation;
    b. Developing a plan of care designed to address those needs;
    c. Coordinating referrals of the member to appropriate service providers and community resources;
    d. Monitoring referrals to ensure the services are received; and
    e. Revising the plan of care, as appropriate.
7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Postpartum" means the period beginning on the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy. For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in Maternity Care quality improvement may utilize different criteria for the Postpartum period.
9. "Postpartum Care" means care provided during the period beginning the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy.
10. "Practitioner" means certified nurse Practitioners in midwifery, physician assistants, and other nurse Practitioners.

11. "Preconception Counseling" means the provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventive care visit and does not include genetic testing.
12. "Prenatal Care" means health care provided during pregnancy and is composed of three major components:
    a. Early and continuous risk assessment,
    b. Health education and promotion including written member educational outreach materials, and
    c. Medical monitoring, intervention, and follow-up.

13. "Providers" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
14. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
15. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following Maternity Care Services are covered for all eligible, enrolled ALTCS members of childbearing age:
    a. Medically necessary Preconception Counseling;
    b. Identification of pregnancy;
    c. Medically necessary education and written member educational outreach materials;
    d. Treatment of pregnancy-related conditions;
    e. Prenatal services for the care of pregnancy;
    f. Labor and delivery services;
    g. Postpartum Care;
    h. Outreach;
    i. Family Planning Services and Supplies; and
    j. Related services.
2. The Division shall require all Maternity Care Services to be delivered by qualified Providers and in compliance with the most current ACOG standards for obstetrical and gynecological services.

3. The Division shall allow LM's to provide Prenatal Care, labor, delivery, and Postpartum Care services within their scope of practice, while adhering to AHCCCS risk-status consultation and referral requirements.
4. The Division shall require all cesarean sections include medical documentation of medical necessity.
    a. The Division shall require all inductions and cesarean sections done prior to 39 weeks follow the ACOG guidelines.
    b. The Division shall require any inductions performed prior to 39 weeks or cesarean sections performed at any time that are found not to be medically necessary are not eligible for payment.
    c. The Division shall require related services such as outreach and Family Planning Services and Supplies are covered, when appropriate, based on the member's current eligibility and enrollment as specified in AMPM 420.

B. REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

1. The Division shall have a written Maternity and Family Planning Services Annual Plan as specified in AMPM 410 that addresses:
   a. Minimum requirements;
   b. Objectives that are focused on achieving Division and AHCCCS requirements; and
   c. Monitoring and evaluation activities for these minimum requirements as specified in AMPM Exhibit 400-2A and AMPM 410.
2. The Division shall require the AdSS to establish and operate a Maternity Care program with program goals directed at achieving optimal birth outcomes.
3. The Division shall coordinate care for THP Members to ensure the same requirements are met.
4. The Division shall require the following minimum requirements of the Maternity Care program are met:
   a. Sufficient numbers of qualified local personnel to meet the requirements of the Maternity Care program for eligible enrolled Members and achieve contractual compliance;

b. Provision of written Member educational outreach utilizing mechanisms for Member dissemination to meet the following requirements as specified in AMPM Exhibit 400-3:

i. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation;

ii. Healthy pregnancy measures addressing at a minimum:

a) Nutrition;

b) Sexually transmitted infections;

c) HIV testing;

d) Alcohol, opioids, and substance use and other risky behaviors;

e) Measures to reduce risks for low or very low infant birth weight; and

f) Recognizing active labor.

iii. Dangers of lead exposure to birthing mother and baby during pregnancy and how to prevent exposure;

iv. Postpartum depression;

v. Postpartum services available and the importance of timely prenatal and Postpartum Care;

vi. Provision of information regarding the opportunity to change health plans to ensure continuity of Prenatal Care to newly assigned pregnant women and those currently under the care of an out-of-network Provider;

vii. Postpartum warning signs that require contacting a Provider;

viii. Maternity Care practices that are supportive of breastfeeding, and breastfeeding information;

ix. Safe sleep and ways to reduce Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) risk;

x. Interconception spacing recommendations and family planning options, including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) as specified in AMPM Policy 420;

xi. Ways to minimize interventions during labor and birth as recommended by ACOG;

xii. Support resources and programs such as:

a) Arizona Supplemental Nutrition Program for Women, Infants, and Children (WIC),

b) Strong Families AZ home visitation programs,

c) Arizona Department of Health Services breastfeeding hotline,

d) Early Head Start or Head Start, and

e) Birth to Five Helpline.

xiii. Information on how to obtain pregnancy related services and assistance with scheduling appointments;

xiv. A statement that there is no copayment or other charge for pregnancy-related services as specified in ACOM Policy 431;

xv. A statement that assistance with medically necessary transportation is available to obtain pregnancy

related services as specified in AMPM Policy 310-BB; and

xvi. Other selected topics.

c. Implementation of written protocols to inform pregnant women and Maternity Care providers of voluntary prenatal HIV or AIDS testing, and the availability of medical counseling and treatment, as well as the benefits of treatment, if the test is positive.

i. The Division shall require the AdSS to include information to encourage pregnant women to be tested and provide instructions on where testing is available as specified in AMPM Exhibit 400-3.

ii. The Division shall require the AdSS to report the number of pregnant women who are HIV or AIDS positive, as specified in Contract, and AMPM 410 Attachment A.

d. Conducting outreach and educational activities to identify currently enrolled Members who are pregnant and enter them into Prenatal Care as soon as possible.

i. The Division shall require programs include protocols for service Providers to notify the AdSS promptly when Members have tested positive for pregnancy.

ii. The Division shall require the AdSS to notify the Division at maternalandchildhealth@azdes.gov and dddcctreferral@azdes.gov when Members have tested positive for pregnancy.

iii. The Division shall require the AdSS to have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant women and implement different activities if activities prove to be ineffective.

e. Participation in community and quality initiatives, including but not limited to, efforts to reduce maternal mortality and morbidity and address health disparities in maternal and infant health within the communities served by the AdSS.

f. Designation of a Maternity Care Provider for each Member who is pregnant for the duration of her pregnancy and Postpartum Care.

i. The Division shall require the AdSS to allow for freedom of choice, while not compromising the continuity of care.

ii. The Division shall require the AdSS to allow Members who transition to a different AdSS or become newly enrolled with an AdSS during their third trimester to complete Maternity Care with their current AHCCCS registered Provider, regardless of contractual status, to ensure continuity of care.

g. Written new Member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool from ACOG covering psychosocial, nutritional, medical and educational factors.

h. Mandatory Maternity Care Coordination services for all pregnant women to include:

i. Identified barriers with navigating the health care system, evident by missed visits,

ii. Difficulties with transportation, or

iii. Other perceived barriers.

i. Demonstration of an established process for assuring:

i. Network Physicians, Practitioners, and LMs adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults or referrals for increased-risk or high-risk pregnancies using ACOG criteria;

ii. Maternity Care Providers educate Members about healthy behaviors during the perinatal period, including:

a) The importance of proper nutrition;

b) Dangers of lead exposure to birthing mother and child;

c) Tobacco cessation;

d) Avoidance of alcohol and other harmful substances, including illegal drugs;

e) Prescription opioid use;

f) Screening for sexually transmitted infections;

g) The physiology of pregnancy;

h) The process of labor and delivery;

i) Breast-feeding;

j) Other infant care information;

k) Interconception health and spacing;

l) Family planning services and supplies, including IPLARC;

m) Postpartum follow-up; and

n) Other education as needed for optimal outcomes.

iii. Members are referred for the following support services to:

a) Special Supplemental Nutrition Program for WIC,

b) Home visitation programs for pregnant women and their children, and

c) Other community-based resources to support healthy pregnancy outcomes.

iv. Maternity care providers maintain a complete medical record, documenting all aspects of Maternity Care;

v. Pregnant women have been referred to and are receiving appropriate care from a qualified physician; and

vi. Postpartum services are provided to Members within the time frame that aligns with performance measures as specified in AMPM 970.

j. Mandatory provision of initial Prenatal Care appointments within the following established timeframes and as specified in ACOM Policy 417:

i. First trimester - within 14 calendar days of a request for an appointment;

ii. Second trimester - within seven calendar days of a request for an appointment;

iii. Third trimester - within three business days of a request for an appointment; or

iv. High risk pregnancies as expeditiously as the Member's health condition requires and no later than three business days of identification of high risk by the AdSS, Division or Maternity Care Provider or immediately, if an emergency exists.

k. Verification of Members who are pregnant, to ensure that the above timeframes are met, and to effectively monitor Members are seen in accordance with those timeframes.

l. Monitoring and evaluation of infants born with low or very low birth weight, and implementation of interventions to decrease the incidence of infants born with low or very low birth weight.

m. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, and implementation of interventions to decrease occurrence, including addressing variations in provider cesarean section rates for first-time pregnant women with a term, singleton baby in a vertex or head down position.

n. Monitoring and evaluation of maternal mortality and implementation of interventions to decrease the occurrence of pregnancy-related mortality and health disparities in both the prenatal and Postpartum period.

o. Monitoring and evaluation to ensure that Maternity Care practices that support breastfeeding success are being utilized per ACOG and American Academy of Pediatrics (AAP) guidance.

p. Identification of Postpartum depression with the required use of any norm-criterion referenced validated screening tool to assist the Provider in assessing the Postpartum needs of women regarding depression and decisions regarding health care services provided by the Maternity Care Provider or subsequent referral for behavioral health services if clinically indicated.

q. Process for monitoring Provider compliance for perinatal and Postpartum depression screenings conducted at least once during the pregnancy and then repeated at the

Postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

r. Return visits scheduled in accordance with ACOG standards. A process shall be in place to monitor these appointments and ensure timeliness.

s. Inclusion of the first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider on claim forms to AHCCCS regardless of the payment methodology.

t. Continued payment of obstetrical claims upon receipt of claim after delivery and shall not postpone payment to include the Postpartum visit. The AdSS shall require a separate zero-dollar claim for the Postpartum visit.

u. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB.

v. Monitoring and evaluation of Postpartum activities and implementation of interventions to improve the utilization rate where needs are identified.

w. Participation in reviews of the Maternity Care Services program conducted by the Division as requested, including Provider visits and audits.

C. MATERNITY CARE PROVIDER REQUIREMENTS

1. The Division shall require Providers adhere to the following Maternity Care requirements:
   a. Maternity Care Providers follow the ACOG standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.
   b. LMs, if included in the AdSS Provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.
2. The Division shall monitor the AdSS to ensure that all Maternity Care Providers adhere to the following:
   a. Division Members have been referred to a qualified Provider and are receiving appropriate care;
   b. All pregnant women are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester and appropriate intervention and counseling

shall be provided, including referral of Members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment, for those Members receiving opioids;

c. All pregnant women are screened for Sexually Transmitted Infections (STI), including syphilis during:
   i. First prenatal visit,
   ii. Third trimester, and
   iii. Time of delivery.

d. Members are educated about the following healthy behaviors during pregnancy:
   i. The importance of proper nutrition;
   ii. Dangers of lead exposure to birthing mother and child;
   iii. Tobacco cessation;
   iv. Avoidance of alcohol and other harmful substances, including illegal drugs;
   v. Prescription opioid use;
   vi. Screening for sexually transmitted infections;

vii. The physiology of pregnancy;

viii. The process of labor and delivery;

ix. Breastfeeding;

x. Other infant care information;

xi. Interconception health and spacing;

xii. Family Planning Services and Supplies, including IPLARC;

xiii. Postpartum follow-up; and

xiv. Other education as needed for optimal outcomes.

e. All pregnant women receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed,

f. Providers utilize evidence-based practices per ACOG and the AAP to increase the initiation and duration of breastfeeding including:

i. Provider recommendation for breastfeeding;

ii. Placement of the infant in skin-to-skin contact;

iii. Early initiation of breastfeeding;

iv. No food or drink other than breastmilk; unless medically necessary; and

v. Rooming in.

g. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the Postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.

i. Postpartum depression screening is not a separately reimbursable service as it is considered part of the global service.

ii. Providers shall refer to any norm-referenced validated screening tool to assist the Provider in assessing the Postpartum needs of birthing mother regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to a behavioral health Provider, if clinically indicated.

h. Member medical records are appropriately maintained and document all aspects of the Maternity Care provided.

i. Members are referred to the following for support services to support healthy pregnancy and infant outcomes:

   i. Special Supplemental Nutrition Program for Women, Infants and Children (WIC),

   ii. Strong Families Az home visiting programs,

   iii. Arizona Department of Health Services breastfeeding hotline,

   iv. Birth to Five Helpline, and

   v. Other community-based resources.

j. Members are notified where they may obtain low-cost or no-cost maternity services, in the event they lose AHCCCS eligibility.

k. The first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider are submitted on all claim forms, regardless of the payment methodology used.

l. Postpartum services as clinically indicated are provided to Members within the Postpartum period and adhere to current AHCCCS minimum performance measures.

1. The Division shall require Maternity Care Providers utilize a separate zero-dollar claim for the Postpartum visit.

D. PREGNANCY TERMINATION

1. The Division shall cover pregnancy termination, if one of the following criteria is present:

   a. The pregnant woman suffers from the following, which places the Member in danger of death unless the pregnancy is terminated, as certified by a physician:

      i. A physical disorder;

      ii. Physical injury; or

      iii. Physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself.

   b. The pregnancy is a result of incest;

   c. The pregnancy is a result of rape; or

d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant woman by:

i. Creating a serious physical or behavioral health problem for the pregnant woman;

ii. Seriously impairing a bodily function of the pregnant woman;

iii. Causing dysfunction of a bodily organ or part of the pregnant woman;

iv. Exacerbating a health problem of the pregnant woman; or

v. Preventing the pregnant woman from obtaining treatment for a health problem.

2. The Division shall require the following to be met regarding Prior Authorization (PA) except in cases of medical emergencies:

a. The Provider obtains a prior authorization for all covered pregnancy terminations;

b. The attending physician submits a request for review of the pregnancy termination qualifying diagnosis and condition for enrolled pregnant women with clinical information that supports the medical necessity or other criteria met for the procedure;

c. The Division reviews the prior authorization request, as specified in AMPM 410 Attachments C and D, and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination;

d. The attending physician submits all documentation of medical necessity within two working days of the date on which the pregnancy termination procedure was performed, in cases of medical emergencies.

3. The Division shall require that any decision to deny or authorize a service is made by a Healthcare Professional who has appropriate clinical expertise in treating the Member's condition or disease.

4. The Division shall require authorization requests for the following services are submitted to the Division, by the AdSS or directly from the Provider for a THP Member, for Second Level Review prior to issuing a decision:
    a. Hysterectomy;
    b. Sterilization; or
    c. Termination of pregnancy.
5. The Division shall review and respond to standard service authorization requests within seven business days and two business days for expedited service authorization requests.
6. The Division shall require expedited requests be clearly labeled as expedited.
7. The Division shall allow the AdSS Medical Director to request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.
8. The Division may request a peer-to-peer directly with the Provider at the Division's discretion for THP Members.
9. The Division shall require:

a. A written consent obtained by the Provider and file in the Member's medical record for a pregnancy termination;

b. If the pregnant woman is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. § 14-5101, a dated signature from the Responsible Person indicating approval of the pregnancy termination procedure is required;

c. When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed;

d. The documentation requirement above in subsection (c) is waived if the treating physician certifies that, in his or her professional opinion, the Member was unable, for physical or psychological reasons, to comply with the requirement;

e. Providers follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy, current standards of care per ACOG shall be

utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected;

f. Pregnancy termination by surgery or standard of care is recommended in cases when medications are used and fail to induce termination of the pregnancy;

g. When medications are administered to induce termination of the pregnancy, the following documentation is also required:

i. Name of medications used,

ii. Duration of pregnancy in days,

iii. The date medication was given,

iv. The date any additional medications were given unless a complete abortion was already confirmed, and

v. Documentation that pregnancy termination occurred.

8. The Division shall require the following reporting requirements are submitted to AHCCCS and the Division:

a. AHCCCS Certificate of Necessity for Pregnancy Termination and AHCCCS Verification of Diagnosis by AdSS for

Pregnancy Termination Requests, AMPM 410 Attachments C and D, as specified in Contract; and

b. Pregnancy Termination Report and the required documentation as listed in AMPM 410 Attachment E, as specified in Contract.

9. The Division shall require the AdSS to develop procedures to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

E. ADDITIONAL RELATED SERVICES

1. The Division shall cover circumcision for males as follows:
   a. Circumcision for males, only when it is determined to be medically necessary, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
   b. Routine circumcision for newborn males is not a covered service; and
   c. The procedure requires Prior Authorization (PA) if required by the newborn's Health Plan.
2. The Division shall require home uterine monitoring technology is covered when determined to be medically necessary as follows:

a. Covered for Members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

b. If the Member has one or more of the following conditions, home uterine monitoring may be considered for:

i. Multiple gestation, particularly triplets or quadruplets;

ii. Previous obstetrical history of one or more births before 35 weeks gestation;

iii. For a pregnant woman ready to be discharged home after hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis.

c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily Provider contact by telephone or home visit.

3. The Division shall require labor and delivery services provided in Free Standing Birthing Centers are covered.

a. For Members who meet medical criteria specified in this policy when labor and delivery services are provided by Maternity Care Providers.

b. Only Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a Free Standing Birthing Center.

c. Risk status shall be determined by the attending physician or Certified Nurse Midwife (CNM), using the standardized ACOG assessment tools for high-risk pregnancies. In any area of the risk assessment where standards conflict, the most stringent will apply.

d. The age of the Member shall also be a consideration in the risk status evaluation as Members younger than 18 years of age are generally considered high risk.

e. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in Free Standing Birthing Centers.

4. The Division shall require labor and delivery services in a home setting provided by the Member's maternity Provider are covered.
    a. For Members who meet medical criteria, AHCCCS covers labor and delivery services provided in the home by:
        i. Member's maternity Provider physicians,
        ii. CNMs, or
        iii. LMs.
    b. Only AHCCCS Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the Member's home.
    c. Risk status is initially determined at the time of the first visit, and each trimester thereafter, by the Member's Maternity Care Provider, using the current standardized ACOG assessment criteria and protocols for High-Risk Pregnancies.

d. A risk assessment conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified Provider, if necessary.

e. Physicians and CNMs who render home labor and delivery services have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and delivery.

f. LMs who render home labor and delivery services have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided for each anticipated home labor and delivery.

g. Referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, are included in the plan of action.

h. The Maternity Care Provider notifies the birthing mother's AdSS or the AHCCCS Newborn Reporting Line of the birth

for infants born to THP Members. Notification is given no later than three days after the birth in order to enroll the newborn with AHCCCS.

5. The Division shall require licensed midwife services are provided by LMs for Members, if LMs are included in the AdSS' Provider network or AHCCCS registered Providers who accept THP.
   a. Members who choose to receive maternity services from this Provider type meet eligibility and medical criteria specified in this policy.
   b. Risk status is initially determined at the time of the first visit, and each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from ACOG.
   c. An ACOG risk assessment is conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified Provider, if necessary.
   d. Before providing midwife services, documentation certifying the risk status of the Member's pregnancy is submitted to the AdSS or to DFSM for THP Members.

e. A consent form signed and dated by the Member is submitted, indicating that the Member has been informed and understands the scope of services that will be provided by the LM, including the risks to a home delivery.

f. Members are immediately referred to an AHCCCS registered physician for THP or within the Provider network of the Member's AdSS for Maternity Care Services who:

   i. Are initially determined to have a High-Risk Pregnancy, or

   ii. Members whose physical condition changes to high-risk during the course of pregnancy.

g. Labor and delivery services provided by a LM cannot be provided in a hospital.

   i. LMs shall have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise.

ii. This plan of action is submitted to the DFSM Medical Director or designee for THP Members, or to the AdSS Medical Director or designee for Members enrolled with an AdSS.

h. Upon delivery of the newborn, the LM is responsible for conducting newborn examination procedures, including:

i. A mandatory Bloodspot Newborn Screening Panel,

ii. A referral of the infant to an appropriate health care Provider for a mandatory hearing screening,

iii. A second mandatory Bloodspot Newborn Screening Panel, and

iv. A second newborn hearing screening.

i. The LM shall notify the birthing mother's AdSS or the AHCCCS Newborn Reporting Line for infants born to THP Members, of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

D. AdSS OVERSIGHT AND MONITORING

1. The Division shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and

recommendations to refine processes, identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes a review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Oct 21, 2023 09:07 PDT)
Anthony Dekker, D.O.

411 WOMEN'S PREVENTIVE CARE SERVICES

REVISION DATES: 6/08/2022, 10/1/2021, 7/3/2019
EFFECTIVE DATE: May 27, 2016

PURPOSE

This policy establishes requirements for well-woman preventive care visits as a covered benefit for women to obtain the recommended preventive services, including Preconception Counseling.

DEFINITIONS

1. "Clinical Breast Exam" means a physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

2. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member's lifestyle and provision of indicated supplies.

3. "Human Papillomavirus (HPV)" means a sexually transmitted infection for which a series of immunizations are available for both males and females.

4. "Mammogram" means an x-ray of the breasts used to look for early signs of breast cancer.

5. "Preconception Counseling" means the purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy by identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. Preconception Counseling is considered included in the well-woman preventive care visit.

POLICY

A. A well-woman preventive care visit is covered on an annual basis.

B. Well-Woman Preventive Care Services include:

1. Well Exam - An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems,

and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes.

C. Requirements for Well-Woman Preventive Care Services:

1. The Division's contracted health plans are responsible for covering Well- Woman Preventive Care Services for Division members enrolled in one of the subcontracted health plans in accordance with AdSS Policy 411.

D. AdSS Oversight And Monitoring

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 15:37 PDT)
Anthony Dekker, D.O.

420 FAMILY PLANNING SERVICES AND SUPPLIES

REVISION DATE: 1/10/2024, 9/6/2023, 6/8/2022, 10/1/2021, 10/01/2019, 8/22/2018, 7/3/2015, 9/15/2014
REVIEW DATE: 9/14/2023
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §36.2904(L), ACOM Policy 405, AMPM 420

PURPOSE

This policy establishes requirements and describes covered services regarding Family Planning Services and Supplies for Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Business Days" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Family Planning Provider" means individuals who are involved in providing family planning services to individuals and may include physicians, physician assistants, nurse practitioners, nurse midwives, midwives, nursing staff and health educators.
3. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a

healthcare provider to allow Members to make informed decisions about the specific family planning methods available that align with the Member's lifestyle and provision of indicated supplies. Family Planning Services and Supplies include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy.

4. "Hysterosalpingogram" means an X-ray procedure used to confirm sterility (occlusion of the fallopian tubes).
5. Immediate Postpartum Long-Acting Reversible Contraceptives" or "IPLARC" means immediate postpartum placement of reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.
6. "Long-Acting Reversible Contraceptives" or "LARC" means reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.

7. "Maternity Care Provider" means the following provider types who may provide maternity care when it is within their training and scope of practice:
    a. Arizona licensed allopathic or osteopathic physicians who are obstetricians or general practice or family practice providers who provide maternity care services,
    b. Physician Assistant,
    c. Nurse Practitioners,
    d. Certified Nurse Midwives, and
    e. Licensed Midwives
8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
9. "Reproductive Age" means Division Members, regardless of gender, from 12 to 55 years of age.
10. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division

Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require Family Planning Services and Supplies to be covered for Members when provided by the appropriate Family Planning Providers or Maternity Care Providers, regardless of gender, who voluntarily choose to delay or prevent pregnancy.
2. The Division shall require that Family Planning services provided are within each provider's training and scope of practice.
3. The Division shall require the provision of medically accurate information and counseling to allow Members to make informed decisions about specific family planning methods available.
4. The Division shall ensure Members enrolled with a health plan maintain the option to choose Family Planning Services and Supplies from any appropriate provider regardless of whether or not the Family Planning Service Providers are network providers.

5. The Division shall ensure Members enrolled with DDD Tribal Health Program (THP) have the option to select any AHCCCS-registered Family Planning Provider.
6. The Division shall ensure pregnant or postpartum Members whose AHCCCS eligibility continues, may remain with their assigned maternity provider, or may select another provider for Family Planning Services and Supplies.

B. SECOND LEVEL REVIEW

1. The Division shall review the following services prior to approval or denial by the AdSS:
   a. Hysterectomy,
   b. Sterilization, or
   c. Termination of pregnancy.
2. The Division shall ensure the AdSS submits the following clinical documentation to support medical necessity for requested services:
   a. Medical records related to the request;
   b. AHCCCS Certificate of Necessity for Pregnancy Termination, if applicable;

c. Verification of diagnosis by contractor for a Pregnancy Termination, if applicable; and

d. Consent to Sterilization, if applicable.

3. The Division shall require the AdSS to submit requests in a timely manner, at minimum, seven Business Days, for review and response for standard service authorization requests.

4. The Division shall require the AdSS to submit expedited service requests within two Business Days and clearly label these requests as expedited.

5. The Division may request a peer-to-peer review with the AdSS Medical Director if there is a disagreement regarding a service authorization.

6. The Division shall make the final decision on prior authorization requests elevated for Second Level Review.

C. AMOUNT, DURATION, AND SCOPE

1. The Division shall require the AdSS to cover the following Family Planning Services and Supplies for Members:

a. Contraceptive counseling, medication, and supplies:

i. Oral and injectable contraceptives;

ii. LARC;

iii. IPLARC;

iv. Diaphragms;

v. Condoms;

vi. Foams; and

vii. Suppositories.

b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning;

c. Treatment of complications resulting from contraceptive use, including emergency treatment;

d. Natural family planning education or referral to other qualified health professionals;

e. Post-coital emergency oral contraception, excluding Mifepristone (Mifeprex or RU-486) within 72 hours after unprotected sexual intercourse; and

f. Sterilization by Hysteroscopic Tubal Sterilization or Vasectomy

i. The Division shall require the provider counsels and recommends the Member continue another form of birth control to prevent pregnancy for up to 3 months following the Hysteroscopic Tubal Sterilization or Vasectomy.

ii. The Division shall require the provider to perform a Hysterosalpingogram or sperm count according to the current standard of care for the sterilization procedure to confirm the Member is sterile following the Hysteroscopic Tubal Sterilization or Vasectomy.

2. The Division shall ensure the following Family Planning Services and Supplies are covered:

a. Pregnancy screening;

b. Pharmaceuticals when associated with medical conditions related to family planning or other medical conditions;

c. Screening and treatment for Sexually Transmitted Infections (STI) for Members, regardless of gender;

d. Sterilization, regardless of Member's gender, when the requirements for sterilization services are met; and

e. Pregnancy termination only as specified in AMPM Policy 410.

3. The Division shall ensure service providers are aware the following services are not covered for the purpose of Family Planning Services and Supplies:

a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility;

b. Pregnancy termination counseling;

c. Pregnancy terminations, except as specified in AMPM Policy 410; and

d. Hysterectomy for the purpose of sterilization.

D. REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES AND SUPPLIES

1. The Division shall monitor required Member outreach per AMPM Exhibit 400-3 to notify Members of Reproductive Age, regardless of gender, of the specific covered Family Planning Services and Supplies available and how to request them.

2. The Division shall require the AdSS to ensure the following information is provided to Members:

a. A complete description of available covered Family Planning Services and Supplies,

b. Information advising how to request or obtain these services,

c. Information that assistance with scheduling is available,

d. A statement that there is no copayment or other charge for Family Planning Services and Supplies as specified in ACOM Policy 431, and

e. A statement that medically necessary transportation services as specified in AMPM 310-BB are available.

3. The Division shall require the AdSS to have policies and procedures in place to ensure Family Planning Providers are educated regarding covered and non-covered services, Family Planning Services and Supplies, including LARC and IPLARC options.

4. The Division shall ensure Family Planning Services and Supplies are:

a. Provided in a manner free from coercion or behavioral or mental pressure;

b. Available and easily accessible to Members;

c. Provided in a manner which assures continuity and confidentiality;

d. Provided by, or under the direction of, a qualified physician or practitioner; and

e. Documented in the medical record that each Member of Reproductive Age was notified verbally or in writing of the availability of Family Planning Services and Supplies.

5. The Division shall require the AdSS to ensure providers incorporate medical audits for Family Planning Services and Supplies within Quality Management activities to determine conformity with acceptable medical standards.
6. The Division shall require the AdSS to establish quality or utilization management indicators to effectively measure and monitor the utilization of Family Planning Services.
7. The Division shall require the AdSS to ensure that guidelines detail specific procedures for the provision of LARC or IPLARC and are written in accordance with acceptable medical standards.

8. The Division shall require that the Family Planning or Maternity Care Provider has provided proper counseling to the eligible Member prior to insertion of intrauterine and subdermal implantable contraceptives to increase the Member's success with the device according to the Member's reproductive goals.

E. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING SERVICES

1. The Division requires the AdSS to have a process to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions.
2. The Division shall ensure the following minimum requirements are met specific for notification of covered Family Planning Services and Supplies:
    a. Members of Reproductive Age shall be notified either directly or through the Responsible Adult of the specific covered Family Planning Services and Supplies available to them, and a plan to provide those services and supplies to Members who request them by:

i. Provisions for written notification, other than the Member handbook;

ii. Member newsletter; and

iii. Verbal notification during a Member's visit with the PCP.

b. Family Planning notification is sent by the end of the second trimester for pregnant Members and includes information on LARC or IPLARC;

c. The AdSS shall conform to confidentiality requirements as specified in 45 C.F.R. 164.522(b) (i and ii);

d. Communications and correspondence shall be approved by the Division;

e. Distribution at least once per year by November 1st. For Members who enroll with the AdSS after November 1st, notification is sent at the time of enrollment;

f. Notification of the covered Family Planning Services and instructions given to Members regarding how to access these services;

g. Written notification at reading level and easily understood as specified in ACOM 404;

h. Notification in accordance with cultural competency requirements as specified in ACOM Policy 405;

i. The AdSS shall ensure Maternity Care Providers verbally notify Members of the availability of Family Planning Services during office visits; and

j. The AdSS shall report all Members under 21 years of age, undergoing a procedure that renders the Member sterilized, using the AHCCCS Sterilization Reporting Form, AMPM 420 Attachment B and submitting documentation supporting the medical necessity for the procedure.

F. STERILIZATION

1. The Division shall ensure the following criteria are met for the sterilization of a Member to occur:

   a. The Member is at least 21 years of age at the time the consent is signed, using AHCCCS Consent to Sterilization AMPM 420 Attachment A;

   b. The Member has not been declared mentally incompetent;

c. Voluntary consent was obtained by the Member or Responsible Person without coercion;

d. 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

i. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization.

ii. Consent is given at least 30 days before the expected date of delivery in the case of premature delivery.

2. The Division shall ensure any Member requesting sterilization signs the AHCCCS Consent to Sterilization form with a witness present when the consent is obtained as specified in AMPM 420.

3. The Division shall ensure suitable arrangements are made to ensure the information in the consent form is effectively communicated to Members with limited English proficiency or

reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual or auditory limitations as specified in ACOM 404 and ACOM 405.

4. The Division shall ensure the Member receives a copy of the consent form and is offered factual information prior to signing the consent form that includes the following:
   a. Consent form requirements as specified in 42 CFR 441.250;
   b. Answers to questions asked regarding the specific procedure to be performed;
   c. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care or loss of federally funded program benefits;
   d. Advice that the sterilization procedure is considered to be irreversible;
   e. A thorough explanation of the specific sterilization procedure to be performed;
   f. A description of available alternative methods;

g. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used;

h. A full description of the advantages or disadvantages that may be expected as a result of the sterilization;

i. Notification that sterilization cannot be performed for at least 30 days post consent.

5. The Division shall ensure sterilization consents are not obtained when a Member is:

a. In labor or childbirth;

b. Seeking to obtain, or is obtaining, a pregnancy termination; or

c. Under the influence of alcohol or other substances that affect that Member's state of awareness.

G. OVERSIGHT AND MONITORING

1. The Division shall meet with the AdSS at least quarterly to provide:

a. Ongoing evaluation including data analysis,

b. Recommendations to refine processes,

c. Identify successful interventions, and

d. Care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS that includes review of compliance on an annual basis.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 13:00 MST)

Anthony Dekker, D.O.

430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATES: 6/08/2022, 10/01/2019, 3/25/2016, 7/3/2015, 4/15/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 U.S.C. 1396d (a), Division Medical Policy Manual, 310-P

PURPOSE

This policy establishes requirements for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPDST) services.

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Diagnostic" means determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

3. "Early" means in the case of a child already enrolled with an AHCCCS Contractor, as soon as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

4. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Periodic" means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

6. "Screening" means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more

definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

7. "Treatment" means any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening.

POLICY

A. EPSDT / Well Child Visit

The EPSDT/Well Child visit is all-inclusive and includes the following:

1. A comprehensive health and Developmental history, including growth and Developmental Screening which includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention website: www.cdc.gov/growthcharts/ for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Screening provided by a primary care physician (PCP).

3. Nutritional Assessment provided by a PCP, refer to AdSS Medical Policy 430.

4. Behavioral Health Screening and Services provided by a PCP.

    a. The Division covers behavioral health services for members eligible for EPSDT. PCPs may provide behavioral health services within their scope of practice.

    b. American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment.

5. Developmental Surveillance shall be performed with the PCP at each EPSDT visit.

6. A comprehensive unclothed physical examination.

7. Immunizations

    a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules.

b. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine.

c. Providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

8. Laboratory tests

a. Laboratory including, anemia testing and Diagnostic testing for sickle cell trait.

b. EPSDT covers blood lead Screening for all members at 12 months and 24 months of age and for those members between the ages of 24 through 6 years of age who have not been previously tested or who missed either the 12 month or 24 month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parent/responsible person's concerns. Additional

Screening for children under 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

9. Health education, counseling, and chronic disease self-management.

10. Oral Health Screening

    a. Appropriate oral health Screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant, or nurse practitioner.

    b. Fluoride varnish is limited in a primary care provider's office to 1 every 6 months, during an EPSDT visit for children who have reached 6 months of age with at least 1 tooth erupted, with recurrent applications up to 2 years of age.

11. Appropriate vision, hearing, and speech Screenings

a. EPSDT covers eye examinations as appropriate to age per the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools.

b. Ocular photo screening with interpretation and report, bilateral is covered for children ages three through 6 as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional chart-based vision Screening techniques. Ocular photo screening is limited to a lifetime coverage limit of 1.

c. Automated visual Screening is for vision Screening only, and not recommended for or covered when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

d. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT Screenings, subject to medical necessity. Frames for eyeglasses are also covered.

12. Tuberculosis (TB) Screening

a. Tuberculin skin testing as appropriate to age and risk.

b. Confirmed or suspected as having TB,

c. In jail or prison during the last 5 years,

d. Living in a household with an HIV-infected individual or the child is infected with HIV, and/or

e. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

B. Sick Visit Performed in Addition to an EPSDT

A “sick visit” can be performed at the same time as an EPSDT visit:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation Management service, and.

2. The “sick visit” is documented on a separate note.

3. History, exam, and member/responsible person components of the separate “sick visit” already performed during an EPSDT visit are not to be considered when determining the level of the additional services. An insignificant or trivial

problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.

C. AdSS Specific Requirements

For AdSS specific requirements, see AdSS Medical Policy 430.

D. Requirements for the EPSDT Program Plan Checklist

The Division and AdSS shall have a written EPSDT Program Plan Checklist that addresses minimum requirements. For AdSS specific requirements, see AdSS Medical Policy 430.

1. Provider Requirements

   EPSDT services shall be provided according to community standards of practice and Division rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules. Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of screening services.

a. Providers are required to provide health counseling/education at initial and follow-up visits.

b. Refer to the specific AdSS for managed care members and to the Division for Tribal Health Plan (THP) members, regarding (Prior Authorization) PA requirements.

c. A PCP referral is not required for Naturopathic services.

2. Additionally, providers shall adhere to the below specific standards and requirements for the following covered services, see AdSS Medical Policy 430:

a. Breastfeeding Support

b. Immunizations

c. Blood Lead Screening

d. Organ and Tissue Transplantation Services

Refer to AMPM Policy 310-DD for information regarding AHCCCS-covered transplants.

e. Metabolic Medical Foods

If a Division member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to AMPM Policy 310-GG.

f. Nutritional Therapy

i. The Division covers nutritional therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

ii. PA is required from the AdSS or Tribal ALTCS Case Manager or The Division for Tribal Health Plan (THP) members for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy.

g. Oral Health Services

As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health Screening. A Screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy, see AMPM Policy 431.

h. Cochlear and Osseointegrated Implantation

i. Cochlear implantation

j. Conscious Sedation

The Division covers conscious sedation for members receiving EPSDT services.

k. Behavioral Health Services

The Division covers behavioral health services for members eligible for EPSDT services as described in Contract and Policy. EPSDT behavioral health services include the services necessary to correct or ameliorate

mental illnesses and conditions discovered by the Screening services.

For the diagnosis of behavioral health conditions including, but not limited to Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

l. Religious Non-Medical Health Care Institution Services

The Division covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

m. Care Management Services

The Division covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a

child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

n. Chiropractic Services

The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS to ameliorate the member's medical condition.

o. Personal Care Services

The Division covers personal care services, as appropriate, for members eligible for EPSDT services.

p. Incontinence Briefs

q. Medically Necessary Therapies

The Division covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the Screening services. Therapies are

covered under both an inpatient and outpatient basis when medically necessary.

E. AdSS Oversight and Monitoring

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 16:32 PDT)

Anthony Dekker, D.O.

431 DENTAL/ORAL HEALTH SERVICES FOR EPSDT ELIGIBLE MEMBERS

REVISION DATE: 2/7/2024, 6/8/2022, 10/1/2021
REVIEW DATE: 7/26/2023
EFFECTIVE DATE: November 22, 2017
REFERENCES: 42 U.S.C. 1396d(a), 9 A.A.C. 22, Article 2; A.R.S. §36.-551, A.R.S. § 14-5101; AMPM 431 Attachment B, AMPM Policy 430 Attachment A, AMPM Policy 431 Attachment A

PURPOSE

This policy establishes requirements for dental/oral health care for Members under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

DEFINITIONS

1. "Dental Home" means the ongoing relationship between the dentist and the member, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and

includes referral to dental specialists when appropriate. [American Academy of Pediatric Dentistry (AAPD)].

2. "Dental Provider" means an individual licensed as specified in A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
   a. Independently engage in the practice of dentistry as specified in A.R.S. § 32-1202,
   b. A dentist as specified in A.R.S. § 32-1201,
   c. A dental therapist as specified in A.R.S. § 32-1201,
   d. A dental hygienist as specified in A.R.S. § 32-1201, or
   e. An affiliated practice dental hygienist as specified in A.R.S. § 32-1201.
3. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law

42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. "Informed Consent" means an agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by the Member or Responsible Person with no minimization of known dangers of any procedures.
5. "Medically Necessary" means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

7. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or a naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services. The PCP shall be an individual, not a group or association of individuals, such as a clinic.
8. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
9. "Referral" means a verbal, written, telephonic, electronic, or in-person request for health services.

10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551
11. "Screening" means the regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
12. "Treatment Plan" means a written plan of services and therapeutic interventions based on a complete assessment of a Member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require an oral health screening to be conducted by a PCP as part of an EPSDT screening.
2. The Division shall require oral health screenings as part of the physical examination are performed by a:
    a. Physician,
    b. Physician's assistant, or
    c. Nurse practitioner.
3. The Division shall require PCPs to refer EPSDT Members for appropriate services based on needs identified through the screening process and for routine oral health care based on the AHCCCS EPSDT Periodicity Schedule.
4. The Division shall require the Referral be documented on the EPSDT Clinical Sample Template as specified in AMPM Policy 430, Attachment E and in the Member's medical record.
5. The Division shall require one of the following Referrals to a dental provider to be made depending on the results of the oral health screening:
    a. Urgent referrals as expeditiously as the Member's health condition requires, but no later than 3 days of request;

b. Routine referrals within 45 calendar days of request; or

c. Within 30 calendar days of request for the Department of Child Safety (DCS) Comprehensive Health Plan (CHP) only.

6. The Division shall require reimbursement for PCPs who have completed the AHCCCS-required training for fluoride varnish applications completed at the EPSDT visits for Members as early as six months of age with at least one tooth eruption.

7. The Division shall require reimbursement for PCPs according to AHCCCS-approved fee schedules for additional fluoride applications occurring every three months during an EPSDT visit, up until the member's fifth birthday.

8. The Division shall require that PCPs are notified that application of fluoride varnish by the PCP does not take the place of an oral health visit.

9. The Division shall require providers to submit a copy of their certificate upon completion of the required training prior to payment being issued for PCP-applied fluoride varnish.

B. DENTAL HOME

1. The Division shall require that the Dental Home provides:

a. Comprehensive oral health care including acute care and preventive services in accordance with AMPM 431 Attachment A;

b. Comprehensive assessment for oral diseases and conditions;

c. Individualized preventive oral health program based upon a caries-risk assessment and a periodontal disease risk assessment;

d. Anticipatory guidance about the following growth and development issues:

   i. Teething,

   ii. Digit,

   iii. Pacifier habits, or

   iv. Similar issues.

e. A plan for acute dental/oral trauma;

f. Information about proper care of the child's teeth and gingiva, including the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and

the maintenance of health, function, and esthetics of those structures and tissues;

g. Dietary counseling; and

h. Referrals to dental specialists when care cannot directly be provided within the Dental Home.

2. The Division shall require THP Members be referred by a PCP to a Dental Provider by one year of age or upon enrollment.
3. The Division shall require Members enrolled with an AdSS are assigned a dental home by six months of age or upon enrollment, and seen by a Dental Provider for routine preventative care according to the AMPM 431 Attachment A.
4. The Division shall require PCPs to refer Members with identified additional oral health care concerns to a Dental Provider for evaluation or treatment.
5. The Division shall require PCPs are informed to refer EPSDT Members for a dental/oral health assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment or treatment by a Dental Provider.

6. The Division shall require EPSDT Members are informed that they are allowed to self-refer to a Dental Provider who is included in the AdSS provider network.
7. The Division shall allow THP Members to self-refer to any AHCCCS registered Dental Provider.

C. COVERED SERVICES

1. The Division shall require the following EPSDT dental/oral health services are covered:
    a. Emergency dental/oral services including:
        i. Treatment for pain, infection, swelling or injury;
        ii. Extraction of:
            a) Symptomatic, infected, and non-restorable primary and permanent teeth, and
            b) Retained primary teeth.
        iii. General anesthesia, conscious sedation, or anxiolysis sedation where Members respond normally to verbal commands, when local anesthesia is contraindicated or when management of the member requires it, as specified in AMPM 430.

b. Preventive dental/oral health services provided as specified in AMPM Policy 431, Attachment A:

i. Diagnostic services including the following comprehensive and periodic examinations:

a) Two oral examinations, and two oral prophylaxis and fluoride treatments per Member per year for Members up to 21 years of age;

b) Fluoride varnish four times a year for Members up to five years of age; and

c) Additional examinations or treatments deemed Medically Necessary through the AdSS Prior Authorization process.

ii. Radiology services screening for diagnosis of dental abnormalities or pathology, including:

a) Panoramic or full-mouth x-rays;

b) Supplemental bitewing x-rays; and

c) Occlusal or periapical films, as medically necessary and following the recommendations

by the American Academy of Pediatric Dentistry.

iii. Panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit shall be deemed Medically Necessary through the AdSS PA process;

iv. The following preventive services:

a) Oral prophylaxis performed by a Dental Provider that includes self-care oral hygiene instructions to Member, if able, or to the Responsible Person;

b) Application of topical fluorides and fluoride varnish with the exception of a prophylaxis paste containing fluoride or fluoride mouth rinses;

c) Dental sealants for first and second molars are covered twice per first or second molar, per

provider or location, allowing for three years intervention between applications up to 15 years of age which includes the ADHS school-based dental sealant program and the participating providers;

d) Additional applications deemed medically necessary and require prior authorization (PA); and

e) Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the AdSS PA or AHCCCS PA for THP Members.

c. All of the following, although potentially subject to a PA as specified in the AdSS Dental Provider Manuals, when they are considered Medically Necessary and cost effective:

i. Periodontal procedures, scaling and root planing, curettage, gingivectomy, and osseous surgery;

ii. Crowns;

iii. Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless a third molar is functioning in place of a missing molar;

iv. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;

v. Restorations of anterior teeth for children under the age of five, when medically necessary;

vi. Extraction for children five years and over, with primary anterior tooth decay if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the Dental Provider;

vii. Removable dental prosthetics, including complete dentures and removable partial dentures when Medically Necessary;

viii. Orthodontic services and orthognathic surgery, when these services are Medically Necessary to treat a handicapping malocclusion, and are determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the Dental Provider in consultation with each other.

ix. Conditions that require the following orthodontic treatment:

a) Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;

b) Trauma requiring surgical treatment in addition to orthodontic services;

c) Skeletal discrepancy involving maxillary or mandibular structures; or

d) Other severe orthodontic malformations that meet PA criteria.

2. The Division shall not cover services or items furnished solely for cosmetic purposes.

D. PROVIDER REQUIREMENTS

1. The Division shall require that dental/oral health services are provided by AHCCCS-registered Dental Providers.
2. The Division shall require a written Informed Consent for examination or any preventative treatment measure, excluding irreversible or invasive procedure, is completed at the time of initial examination and is updated at each subsequent six months follow-up appointment.
3. The Division shall require a separate written consent is completed for any irreversible or invasive procedure.
4. The Division shall require all Dental Providers review and sign a written Treatment Plan with the Member or Responsible Person receiving a copy of the complete Treatment Plan.
5. The Division shall require all Dental Providers complete the appropriate Informed Consents and Treatment Plans for Division Members in order to provide quality and consistent care in a

manner that protects and is easily understood by the Member or Responsible Person.

6. The Division shall require consents and Treatment Plans are in writing, signed and dated by both the Dental Provider and the Member or Responsible person, if:
   a. The Member is under 18 years of age, or
   b. The Member is 18 years of age or older and considered an incapacitated person as defined in A.R.S. § 14-5101.
7. The Division shall require Dental Providers maintain completed consents and Treatment Plans in the Member's chart which are subject to audit.

E. ADSS REQUIREMENTS

The Division shall ensure the AdSS meets the requirements specified in AdSS Medical Policy 431.

F. REQUIREMENTS FOR THE DENTAL ANNUAL PLAN

1. The Division shall have a written Dental Annual Plan that:
   a. Addresses minimum requirements as specified in this policy;

b. Addresses the objectives of the Division and AdSS programs that are focused on achieving Division requirements; and

c. Incorporate monitoring and evaluation activities for these minimum requirements as outlined in AMPM 431 – Attachment B.

2. The Division shall submit the Dental Annual Plan no later than July 31st to the Division's Dental Director through the Compliance Unit for review and approval.

3. The Division shall require the following is contained in the written Dental Annual Plan:

a. Narrative Plan that includes:

i. A written narrative description of all planned dental activities to address the Division and AdSS minimum requirements for dental/oral health services, as specified in this policy;

ii. A narrative description of the AdSS activities to identify Member needs and coordination of care; and

iii. Follow-up activities to ensure appropriate treatment is received in a timely manner.

b. Dental Work Plan Evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives;

c. Dental Work Plan that includes:

i. Specific measurable objectives based on AHCCCS established Performance Measure Performance Standards (PMPS) as adopted by the Division;

ii. Strategies and specific measurable interventions to accomplish the following objectives:

a) Member outreach,

b) Provider education, and

c) Provider compliance with mandatory components of the Dental Program.

d. Targeted implementation and completion dates of work plan activities;

e. Assigned local staff positions responsible and accountable for meeting each established goal and objective;

f. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation; and

g. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.

F. AFFILIATED PRACTICE DENTAL HYGIENIST

1. The Division shall require the following in addition to the requirements as specified in A.R.S. §§ 32-1281 and 32-1289:

   a. Both the dental hygienist and the dentist in the affiliated practice relationship are registered AHCCCS providers;

   b. The affiliated practice dental hygienist maintains individual patient records of the following for Division Members in accordance with the Arizona State Dental Practice Act:

      i. Member identification,

      ii. Responsible Person identification,

      iii. Signed authorization for services,

iv. Patient medical history, and

v. Documentation of services rendered.

c. The affiliated practice dental hygienist registers with AHCCCS and is identified as the treating Dental Provider under his or her individual AHCCCS Provider identification number or National Provider Identification (NPI) number;

d. The affiliated practice dental hygienist and the dentist with whom he or she is affiliated is a credentialed network provider if the services are to be billed to an AdSS;

e. The affiliated practice dental hygienist is identified as the treating Dental Provider under their individual AHCCCS provider identification number or NPI number when practicing under an affiliated practice agreement;

f. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with:

i. State statute and regulations;

ii. AHCCCS policy;

iii. Division policy;

iv. Provider agreement; and

v. Affiliated practice agreement.

g. Affiliated practice dental hygienists provide documentation of the affiliation practice agreement with an AHCCCS registered dentist that is recognized by the dental board confirming the affiliation agreement.

h. Reimbursement for dental radiographs is restricted to Dental Providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

G. AdSS OVERSIGHT AND MONITORING

The Division shall refer to Division Operations 438 for monitoring and oversight responsibilities of the AdSS.

SUPPLEMENTAL INFORMATION

A Screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. The oral health screening does not substitute for examination through direct Referral to a dental Provider.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website, https://www.aap.org/en/patient-care/oral-health/oral-health-education-and-training/
Refer to the website for training that covers caries-risk assessment, fluoride varnish, and counseling.

Crowns:
Stainless-steel crowns are used for both primary and permanent posterior teeth when appropriate.
Composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth.

Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for Members who are 18 to 21 years of age.

Certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

In cases where the Performance Measure Performance Standards have been met, other generally accepted benchmarks that continue the AdSS improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards).

Dental work plan includes specific measurable goals and objectives aimed at enhancing the Dental Program when the PMPS have been met.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:19 MST)
Anthony Dekker, D.O.

510 PRIMARY CARE PROVIDERS

REVISION DATE: 4/17/2024, 9/6/2023
REVIEW DATE: 5/10/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: AMPM 510

PURPOSE

This policy outlines the requirements applicable to the Division of Developmental Disabilities (Division) regarding Primary Care Providers participating in Arizona Health Care Cost Containment System (AHCCCS) programs.

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. §1-301.
2. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21. EPSDT services include:
    a. Screening services,

b. Vision services,

c. Dental services,

d. Hearing services, and

e. All other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Non-Contracting Provider" means an individual or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.

5. "Primary Care Provider" or "PCP" means a person who is responsible for the management of the member's health care. A PCP may be a:

a. Person licensed as an allopathic or osteopathic physician,

b. Practitioner defined as a licensed physician assistant, or

c. Certified nurse practitioner.

6. "Provider" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

7. "Resident Physician" means doctors who have graduated from medical school and are completing their residency in a specialty.

8. "Teaching Physician" means a physician other than another Resident Physician who involves residents in the care of his or her patients.

POLICY

A. PRIMARY CARE PROVIDER AND RESPONSIBILITIES

The Division shall ensure that PCPs are:

a. Providing initial and primary care services to assigned Members;

b. Initiating, supervising, and coordinating referrals for specialty care and inpatient services;

c. Maintaining continuity of Member care; and

d. Maintaining the Member's medical record as specified in AHCCCS Medical Policy Manual (AMPM) 940.

B. PROVISION OF INITIAL AND PRIMARY CARE SERVICES

1. The Division shall require PCPs to provide the following covered preventive and primary care services to Members:
   a. Health screenings,
   b. Routine illness,
   c. Maternity services if applicable,
   d. Immunizations, and
   e. EPSDT services.
2. The Division shall ensure that all Members under the age of 21 receive health screening and services to correct or ameliorate defects or physical and behavioral illnesses or conditions identified in an EPSDT screening as specified in AMPM Policy 430.
3. The Division shall ensure that Members 21 years of age and over receive health screening and medically necessary treatment as specified in AMPM Chapter 300.

C. BEHAVIORAL HEALTH SERVICES PROVIDED BY THE PRIMARY CARE PROVIDER

1. The Division shall cover medically necessary, cost-effective, Federal and State reimbursable behavioral health services provided by a PCP within their scope of practice.
2. The Division shall require that PCPs obtain prior authorization for antipsychotic class of medications if required, to include monitoring and adjusting behavioral health medication as specified in AMPM 310-V.
3. The Division shall require PCPs to coordinate and collaborate with behavioral health providers.

D. PRIMARY CARE COORDINATION RESPONSIBILITIES

1. The Division shall require PCPs in their care coordination role, serve as a referral agent for specialty and referral treatment, and services for physical or behavioral health services as needed for Members.
2. The Division shall require PCPs to meet the following coordination responsibilities:

a. Referring Members to Providers or hospitals within the AdSS network or AHCCCS registered Providers for Tribal Health Program (THP) Members;

b. Referring Members to Non-Contracting specialty Providers and non-contracting community benefit organizations if necessary;

c. Coordinating services with the Division with the following entities for THP Members:

   i. AHCCCS Division of Fee-For-Service Management (DFSM) for care coordination for physical and behavioral health prior authorizations; and

   ii. THP Members enrolled with the Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health; and

   iii. American Indian Medical Home (AIMH) for coordination of physical and behavioral health services for American Indian Health Program (AIHP) Members enrolled with an AIMH, to include coordination with TRBHAs when applicable.

d. Coordinating when applicable with a Member's:

i. AdSS care manager, including maternity;

ii. Provider case manager;

iii. Division Support Coordinator;

iv. Division Behavioral Health Complex Care Team;

v. Behavioral Health Provider; and

vi. Division Nurses.

e. Conducting or coordinating follow-up for referral services that are rendered to their assigned Members by:

i. Other Providers,

ii. Specialty Providers, or

iii. Hospitals.

f. Coordinating the following medical care of Members:

i. Oversight of medication regimens to minimize side effects or drug interactions;

ii. Follow-up for all emergency services;

iii. Coordination of discharge planning post inpatient admission;

iv. Home visits if medically necessary;

v. Member education;

vi. Preventative health services;

vii. Screening and referral for health-related social needs;

viii. Coordination of the following services:

a) Specialty Providers;

b) Laboratory and Diagnostic Testing;

c) Behavioral health services;

d) Dental services;

e) Therapies including:

1) Occupational,

2) Physical, and

3) Speech language pathology.

f) Durable Medical Equipment;

g) Home health;

h) Palliative care; and

i) Hospice care.

ix. Oversight that care rendered by specialty Providers is appropriate and consistent with each Member's health care needs, and

x. Maintaining records of services provided by physical and behavioral health specialty Providers or hospitals.

g. Coordinating care for behavioral health medication management to include:

i. Require and ensure coordination of referral to the behavioral health Provider when a PCP has initiated medication management services for a Member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the Member should be referred to a behavioral health Provider for evaluation or continued medication management.

ii. Policies and procedures that address the following:

a) Guidelines for PCP initiation and coordination of a referral to a behavioral health Provider for medication management;

b) Guidelines for transfer of a Member with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation for ongoing treatment coordination, as applicable;

c) Protocols for notifying entities of the Member's transfer, including:

    1) Reason for transfer,

    2) Diagnostic information, and

    3) Medication history.

d) Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information;

e) Protocols for transition of prescription services, including:

1) Notification to the appropriate Providers of the Member's current medications and timeframes for dispensing and refilling medications during the transition period,
2) Ensuring that the Member does not run out of prescribed medication prior to the first appointment with the behavioral health Provider, allowing for at least a minimum of 90 days transition between Providers,
3) Forwarding all medical information, including the reason for transfer to the behavioral health Provider prior to the Member's first scheduled appointment.

f) AdSS monitoring activities to ensure that Members are appropriately transitioned for care and receive the services they are referred for.

E. PRIMARY CARE PROVIDER ASSIGNMENT AND APPOINTMENT STANDARDS

1. The Division shall require the AdSS to assign newly enrolled Members to a PCP.
2. The Division shall require the AdSS to notify Members within 12 Business Days of the enrollment notification.
3. The Division shall require that AHCCCS-registered contracted PCPs receive an AHCCCS Provider ID number.
4. The Division shall require the AdSS maintain a current file of Member PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data.
5. The Division shall require the AdSS to make PCP assignment rosters and clinical information regarding Member's health and medications, including behavioral health providers, available to the assigned PCP within 10 Business Days of a Provider's request as specified in ACOM Policy 416.
6. The Division shall allow Members to choose PCPs available within the AdSS network.

7. The Division shall require the AdSS to automatically assign the Member to a PCP if the Member does not select one.
8. The Division shall allow Members to choose an AHCCCS registered PCP if the Member is enrolled with THP.
9. The Division shall monitor that PCPs provide Members with available and accessible services within the time frames specified in ACOM Policy 417.
10. The Division shall require that the AdSS provide information to the Member on how to contact the Member's assigned PCP.
11. The Division shall require that the AdSS assigns pregnant Members to a qualified physician and are receiving appropriate care as specified in AMPM Policy 410.
12. The Division shall require the AdSS assigns Members who are age 12 and younger and who have complex medical conditions to board certified pediatricians.
13. The Division shall require the AdSS to assign Members to Providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

F. REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALITY CARE

The Division shall require that the AdSS oversee appropriate availability and monitoring of health care services and if required, referrals are in place.

G. PHYSICIAN ASSISTANT (PA) AND NURSE PRACTITIONER (NP) VISITS IN A NURSING FACILITY

The Division shall cover initial and any subsequent visits to a Member in a nursing facility made by a PA or NP when all of the following criteria are met:

a. The PA or NP is not an employee of the facility, and

b. The source of payment for the nursing facility stay is Medicaid.

H. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:

   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and

   b. Identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:20 PDT)

Anthony Dekker, D.O.

520 MEMBER TRANSITIONS

REVISION DATE: 03/01/2023
EFFECTIVE DATE: April 1, 2016
REFERENCES: A.R.S. §§36-2931, 36-2901.01 and 36-2981; 42 CFR 431.300, 438.62, 440.70, 457.1216; AMPM 280, AdSS Medical Manual Policy 540, ACOM Policy 402, Division Operations Policy 406

PURPOSE

This policy establishes requirements applicable to the Division of Developmental Disabilities (Division) to identify and facilitate Member transitions between the Administrative Services Subcontractors (AdSS), the Division and other AHCCCS contractors and the Division's oversight of the AdSS.

DEFINITIONS

1. "Enrollment Transition Information" or "ETI" means Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor or Fee-For-Service (FFS) program for those members requiring coordination of services as a result of transitioning to another contractor or FFS program.

2. "Medical Equipment and Appliances" means an item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and
   a. Can withstand repeated use, and
   b. Can be reusable by others or is removable.
3. "Member" means an eligible individual who is enrolled in AHCCCS, as specified in A.R.S. §36-2931, §36-2901.01 and A.R.S.§36-2981.
4. "Member Transition" is the process during which members change from one contractor or Fee-for-Service program to another.
5. "Receiving Contractor" is the contractor with which the Member will become enrolled as a result of Annual Enrollment Choice (AEC), open enrollment, a contractor change or a change in eligibility.
6. "Relinquishing Contractor" is the contractor from which the Member will be leaving as a result of AEC, open enrollment, a contractor change or a change in eligibility.
7. "Special Health Care Needs" or "SHCN" means serious and chronic physical, developmental, or behavioral conditions

requiring medically necessary health and related services of a type or amount beyond that required by Members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP). All Division members are designated as individuals with Special Health Care Needs.

POLICY

A. MEMBER TRANSITIONS

1. The Division shall identify and facilitate coordination of care for all members eligible for Arizona Long Term Care System (ALTCS) during:
   a. Changes or transitions between health plans,
   b. Changes in service areas, or
   c. Changes in health care providers as specified in AMPM 520.
2. The Division shall work collaboratively with Members with special circumstances which may require additional or distinctive assistance during a period of transition such as:
   a. Pregnancy;

b. Major organ or tissue transplantation services which are in process;

c. Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities;

d. Significant medical or behavioral health conditions that require ongoing specialist care and appointments;

e. Chemotherapy and/or radiation therapy;

f. Dialysis;

g. Hospitalization at the time of transition;

h. Members with the following ongoing health needs:

i. Durable Medical Equipment, including ventilators and other respiratory assistance equipment;

ii. Home health services;

iii. Medically necessary transportation on a scheduled basis;

iv. Prescription medications; or

v. Plan management services.

i. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;

j. Members with qualifying Children's Rehabilitation Services (CRS) conditions or are transitioning into adulthood;

k. Members diagnosed with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS);

l. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant;

m. Members enrolled in the ALTCS program who are elderly and/or have a physical or developmental disability;

n. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP);

o. Members who are diagnosed with a Serious Mental Illness (SMI).

p. Any child that has an Early Childhood Service Intensity Instrument/Child and Adolescent Level of Care Utilization System (ECSII/CALOCUS) score of 4+;

q. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system;

r. Substance exposed newborns and infants diagnosed with Neonatal Abstinence Syndrome (NAS);

s. Members diagnosed with Severe Combined Immunodeficiency (SCID);

t. Members with a diagnosis of autism or who are at risk for autism;

u. Members diagnosed with opioid use disorder, separately tracking pregnant Members and Members with co-occurring pain and opioid use disorder;

v. Members enrolled with the Division of Child Safety/Comprehensive Health Program (CHP);

w. Members who transition out of the CHP up to one-year post transition;

x. Members identified as a High Need/High Cost Member;

y. Members on conditional release from Arizona State Hospital;

z. Other services not indicated in the State Plan for eligible Members but covered by Title XIX and Title XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible Members, including Members whose conditions require ongoing monitoring or screening;

3. At the time of transition, have received prior authorization or approval for:

a. Scheduled elective surgery(ies);

b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;

c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30 calendar day period;

d. Behavioral health services;

e. Appointments with a specialist located out of the AdSS service area; and

f. Nursing facility admission.

B. NOTIFICATION REQUIREMENTS

1. The Division shall ensure the relinquishing AdSS provides relevant information regarding Members who are transitioning to a receiving AdSS. The Enrollment Transition Information (ETI) Form shall be utilized for the transfer of information for Members with special circumstances who are transitioning enrollment to an AdSS, FFS program or other contractor.
2. The Division shall ensure the relinquishing AdSS completes and electronically transmits the appropriate ETI Form to the Division no later than 10 business days from date of receipt of the AHCCCS notification.
3. The Division shall ensure the relinquishing AdSS covers the Members care for up to 30 calendar days following the identified transition date if the relinquishing AdSS fails to notify the Division of transitioning Members with special circumstances, fails to send the completed ALTCS Enrollment Transition Information (ETI), or AHCCCS AMPM 520 Attachment for non-ALTCS Division Members.

4. The Division shall ensure the transfer of pertinent medical records as well as the timely notification to Members, subcontractors, or other providers during times of transition.
5. The Division shall provide new Members with a Member Handbook, provider directory and emergency numbers as specified in ACOM 406.
6. The Division shall follow-up with the Member to address the needs of the Member identified on the ETI form. Follow-up and care coordination may include support coordination, care management, pharmacy, behavioral health services, and transportation.
7. The Division, in coordination with AHCCCS DFSM, shall extend previously approved prior authorizations for a minimum of 30 calendar days from the date of the Member's transition unless a different time period is mutually agreed to by the Member or Member's representative.

C. COORDINATION ACTIVITIES

1. The Division's transition coordinator shall:

a. Ensure all pertinent Member information is communicated to support coordination to initiate assessment and review of a newly transitioned Member.

b. Collaborate with the Division internal partners, AHCCCS department and/or AdSS for all identified existing authorizations to be extended for up to 90 calendar days, as appropriate. Activities may include continuation of medically necessary covered services during the transition through any of the following:

   i. Contracting on a negotiated rate basis with the Member's current provider(s),

   ii. Negotiating a single Membercontract,

   iii. Assisting Members with referrals to alternate in-network providers.

c. Communicate with support coordination and, if applicable, Division Care Management to coordinate discharge planning with the relinquishing ALTCS or ACC contractor if the Member is hospitalized at the time of the transition.

d. Notify the behavioral health administrator when a Member who is receiving behavioral health services has transitioned between health plans.

e. Work collaboratively with the support coordinator and the AdSS to:

i. Avoid any disruption in care during the transition, enrollment or disenrollment.

ii. Ensure access to appropriate providers, level of care and facilitate resolution of any barriers though the established processes.

1) The support coordinator may request technical assistance from complex care and behavioral health specialists to ensure Members who are medically complex and require intensive physical, and/or behavioral health support services during the transition to avoid any disruption in care.

2. The support coordinator shall work with the Division transition coordinator and AdSS to ensure access to the appropriate level

of care, appropriate providers and facilitate the resolution of any barriers.

D. TRANSITION FROM CHILD TO ADULT SERVICES

1. The Division shall ensure transitions involving co-occurring behavioral and physical health conditions include the following:
    a. Coordination plan between child providers and the anticipated adult providers;
    b. Process that begins no later than when the child reaches the age of 16;
    c. A transition plan for the Member focused on assisting the Member with gaining the necessary skills and knowledge to become a self-sufficient adult within their capabilities and facilitates a seamless transition from child services to adult services;
    d. An SMI eligibility determination that is completed when the adolescent reaches the age of 17, but no later than age 17 and six months; and
    e. A coordination plan to meet the unique needs for Members with special circumstances.

2. The Division shall ensure additional stakeholder, behavioral or physical healthcare entity involved with the child shall be included in the transition process, as applicable.

E. MEMBERS HOSPITALIZED DURING ENROLLMENT CHANGE

1. The Division shall provide a smooth transition of care for Members who are hospitalized on the day of an enrollment change. These provisions shall include processes for the following:
    a. Notification to the receiving AdSS or FFS Program prior to the date of the transition.
    b. Notification to the hospital and attending physician of the transition by the relinquishing AdSS as follows:
        i. Notify the hospital and attending physician of the pending transition prior to the date of the transition,
        ii. Instruct the providers to contact the receiving AdSS or FFS Program for authorization of continued services,
        iii. Cover services rendered to the hospitalized Member for up to 30 calendar days if they fail to provide

notification to the receiving AdSS, hospital, and the attending physician, relative to the transitioning Member.

c. Coverage of the hospital stay by the AdSS in which the Member is enrolled upon discharge per Diagnosis Related Group (DRG).

d. Coordination with providers regarding activities relevant to concurrent review and discharge planning.

F. TRANSITION DURING MAJOR TRANSPLANTATION SERVICES

1. The Division shall ensure Members who have been approved for a major organ or tissue transplant are covered through the relinquishing or receiving AdSS.
2. The Division shall ensure each AdSS covers the respective dates of service if a Member changes to a different AdSS while undergoing transplantation at a transplant center that is not an AHCCCS contracted provider.

G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT

1. The Division shall ensure ongoing care of Members with active or chronic health care needs during the transition period.
2. The Division shall ensure timely transition of the Member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.
3. The Division shall ensure pregnant women who transition to a new AdSS within the last trimester of their expected date of delivery be allowed the option of continuing to receive services from their established physician and anticipated delivery site through the postpartum visits as specified in AMPM 410.

H. MEDICALLY NECESSARY TRANSPORTATION

1. The Division shall provide information to new Members on what and how medically necessary transportation can be obtained.
2. The Division shall provide information to providers on how to order medically necessary transportation for Members.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

1. The Division shall ensure the relinquishing AdSS:

a. Covers the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment;

b. Does not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100 unit doses; and

c. Provides sufficient continuing medications for up to 15 days after the transition date.

2. The Division shall ensure previously approved prior authorizations are extended for a period of 30 calendar days from the date of the Member's transition unless a different time period is mutually agreed to by the Member or Member's representative.

3. The Division shall ensure Member's transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for behavioral health medication management shall continue on the medication(s) prescribed by the BHMP until the Member can transition to their PCP.

4. The Division shall coordinate care and ensure the Member has a sufficient supply of behavioral health medications to last through the date of the Member's first appointment with their PCP.

J. DISPOSITION OF MEDICAL EQUIPMENT, APPLIANCES, AND MEDICAL SUPPLIES DURING TRANSITION

1. The AdSS shall ensure the disposition of Medical Equipment, appliances, and supplies during a Member's transition period and develop policies that include the following:
    a. Non-customized Medical Equipment
        i. Relinquishing AdSS shall provide accurate information about Members with ongoing Medical Equipment needs to the receiving AdSS or FFS programs.
    b. Customized Medical Equipment
        i. Customized Medical Equipment purchased for Members by the relinquishing AdSS will remain with the Member after the transition. The purchase cost of the equipment is the responsibility of the relinquishing AdSS.

ii. Customized Medical Equipment ordered by the relinquishing AdSS but delivered after the transition to the receiving AdSS shall be the financial responsibility of the relinquishing AdSS.

iii. Maintenance contracts for customized Medical Equipment purchased for Members by a relinquishing AdSS will transfer with the Member to the new AdSS.

iv. Contract payments due after the transition will be the responsibility of the receiving AdSS, if the receiving AdSS elects to continue the maintenance contract.

c. Augmentative Communication Devices (ACD)

i. A 90-day trial period to determine if the ACD will be effective for the Member, or if it should be replaced with another device.

ii. If a Member Transitions from an AdSS during the 90-day trial period, one of the following shall occur:

1) The device shall remain with the Member if the ACD is proven to be effective. Payment for the

device shall be covered by the relinquishing AdSS.

2) The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving AdSS if they elect to continue the maintenance contract.

3) The device shall be returned to the vendor if the ACD is proven to be ineffective. The receiving AdSS shall then coordinate a new device trial and purchase if it is determined to meet the Member's needs.

K. MEDICAL RECORDS TRANSFER

1. The Division shall ensure transition of medical records timely but no later than within 10 business days from receipt of the request for transfer to ensure continuity of Member care during the time of enrollment change as specified in AMPM 940.

L. THERAPEUTIC FOSTER CARE

1. The Division shall work closely with the Department of Child Safety (DCS) and other entities to ensure continuity of care

including access to covered services, treatment and supports, in-network and out-of-network providers as determined by the transition plan for children receiving behavioral health services in out-of-home placement.

a. The Division transition coordinator notifies the Division Behavioral Health Administration and support coordinator of all ALTCS Member transitions between health plans in which Members are receiving behavioral health services, including therapeutic foster care.

b. The Division Behavioral Health Administration provides technical assistance to the support coordinator supervisor to identify circumstances in which the provider is not in the new health plan's network.

c. The Behavioral Health Administration coordinates with the AdSS to ensure continuity of care is maintained for the Member.

M. DIVISION OVERSIGHT RESPONSIBILITIES

1. Health Care Services (HCS) shall review performance data and conduct quarterly meetings with the AdSS to ensure compliance,

evaluate performance, identify opportunities for improvement, make recommendations to refine processes and resolve barriers, identify successful interventions and care pathways to optimize results and improve outcomes.

2. The Division shall review compliance and performance during its annual operational review of the AdSS including performance metrics regarding Member Transitions for children and adults with behavioral health, complex care, and other Special Health Care Needs.

3. The HCS transition coordinator shall report performance metrics regarding Member Transitions to the Medical Management Committee quarterly. These metrics shall include the number of Member Transitions, unresolved barriers or concerns and any recommendations to improve performance.

Signature of Chief Medical Officer: Anthony Dekker (Feb 21, 2023 12:20 MST)

Anthony Dekker, D.O.

530 MEMBER TRANSFERS BETWEEN FACILITIES

REVISION DATE: 4/17/2024, 11/22/2017
REVIEW DATE: 8/18/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 36-2909(B), 42 CFR 422.113, 42 CFR 438.114

PURPOSE

This policy establishes requirements applicable to the Division of Developmental Disabilities (Division) when a Member transitions between facilities.

DEFINITIONS

1. "Emergency" means a serious and unexpected situation requiring immediate action to avoid harm to health, life, property, or environment.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Primary Hospital" means hospitals that are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions

by an organized physician staff and have continuous nursing services under the supervision of registered nurses.

4. "Secondary Hospital" means hospitals capable of providing the majority of hospital based services, both general medical and surgical, often Obstetrician (OB) and other services, but limited with regards to specialist access.
5. "Tertiary Hospital" means hospitals with access to a broad range of specialists and equipment necessary and usually receiving their patients from a large catchment area and referral base.

POLICY

A. TRANSFER BETWEEN FACILITIES

1. The Division shall require the following criteria are met when a transfer is initiated by the Administrative Services Subcontractors (AdSS) between inpatient hospital facilities following an Emergency hospitalization:
   a. The attending Emergency physician, or the attending provider treating the Member, determines that the Member

is stabilized for transfer and will remain stable for the period of time required for the distance to be traveled;

b. The receiving physician agrees to the Member transfer;

c. Transportation orders are prepared specifying:

i. The type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

d. A transfer summary accompanies the Member.

2. The Division shall require compliance with Medicaid Managed Care guidelines regarding the coordination of Post Stabilization Care as specified in 42 CFR 438.114 and 42 CFR 422.113.

3. The Division shall require the following criteria are met when a Member transitions to a lower level of care facility:

a. The Member's condition does not require the full capabilities of the transferring facility; or

b. The Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility; and

c. The receiving physician agrees to a Member transfer;

d. Transportation orders are prepared specifying the:

i. Type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

e. A transfer summary accompanies the Member.

4. The Division shall require the following criteria are met when a Member transfers to a higher level of care facility:

a. The transferring hospital cannot provide the level of care needed to manage the Member beyond stabilization required to transport, or cannot provide the required diagnostic evaluation and consultation services needed;

b. The receiving physician agrees to the Member transfer;

c. Transport orders are prepared which specify:

i. The type of transport,

ii. Training level of the transport crew, and

iii. Level of life support. of transport.

d. A transfer summary accompanies the Member.

5. The Division shall require when the transfer is initiated by the AdSS, the attending Emergency physician or the attending

provider treating the Member and the AdSS Medical Director or designee are responsible for determining whether a particular case meets criteria established in this policy.

B. AdSS OVERSIGHT AND MONITORING

The Division shall refer to Division Operations 438 for monitoring and oversight responsibilities of the AdSS.

SUPPLEMENTAL INFORMATION

Transfer to a lower level of care facility (e.g., Tertiary to Secondary or primary, or Secondary to Primary Hospital, or transfer to a skilled nursing facility).

Transfers to a higher level of care facility (e.g., Primary to Secondary or Tertiary, or Secondary to Tertiary Hospital).

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:15 PDT)
Anthony Dekker, D.O.

540 OTHER CARE COORDINATION ISSUES

REVISION DATE: 7/15/2016, 7/3/2015, 10/1/2015, 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.R.S. §§ 8-546, 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915 (k).

Acute Medical Care

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member. Each subcontracted health plan has an identified liaison to assist with the coordination of care for Division members enrolled through the Arizona Long Term Care System (ALTCS) program.

The Support Coordinator will:

A. Contact the health plan liaison when a member has a concern related to medical services received or needed from the subcontracted health plan; and,

B. Contact HCS when there are issues that cannot be resolved with the liaisons.

Children's Rehabilitative Services

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member receiving medical and behavioral health services from Children's Rehabilitative Services (CRS).

The Support Coordinator will:

A. Contact the CRS liaison when a member has a concern related to medical or behavioral health services received or needed from CRS; and,

B. Contact HCS when there are issues that cannot be resolved with the liaison.

Behavioral Health

When the Planning Document indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate such services with the Regional Behavioral Health Authority (RBHA). Additional information is available on the Arizona Division of Health Services/Division of Behavioral Health Services (ADHS/DBHS) website for each RBHA Provider Manual.

A. Qualified Behavioral Health Professional Consult (QBHP)

The Support Coordinator shall complete an initial consultation and quarterly consultations thereafter with the qualified behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are not required for members who are stable on psychotropic medications and are not receiving any other behavioral health services.

B. Behavioral Health Treatment Plan (From RBHA Provider)

The Behavioral Health Treatment Plan from the RBHA Provider becomes part of the Division's Planning Document. The Support Coordinator must include outcomes relevant to a Behavioral Health Treatment Plan on the Division's Planning Document.

C. Child and Family Teams

The Child and Family Team (CFT) is a group of people that include, at a minimum, the child and the family, a behavioral health representative, the Support Coordinator, and any members important in the child's life who are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the CFT outcomes, with oversight by the behavioral health representative.

Residential Placements

At the time of placement, the Support Coordinator is responsible for the following:

A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/ guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.

B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

Department of Child Safety

The Support Coordinator is responsible for coordinating services with the Department of Child Safety (DCS) Case Manager when a child eligible for Division services is in the custody of DCS.

Department of Economic Security Vocational Rehabilitation

The Support Coordinator/Employment Specialist is responsible for submitting and coordinating referrals to DES Vocational Rehabilitation for employment related services.

Arizona Department of Education/ Local Education Agency

The Division shall coordinate services with the Arizona Department of Education Local Education Agency (LEA) under three distinct circumstances:

A. When the Division makes an out-of-home placement for educational purposes (A.R.S. §15-765, www.azleg.gov);

B. When the Division makes an out-of-home placement of a member receiving public education for other than educational purposes; and,

C. When a child receiving early intervention services (day treatment and training) from the Division reaches ages two years six months and two years nine months, in order to plan for preschool transition.

Residential Placement for Educational Reasons (A.R.S.§15-765)

A.R.S. § 15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment. A.R.S. § 15-765 www.azleg.state.az.us/arizonarevisedstatutes.asp requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child, This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.
When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can maintain placement, transition into the district when specific behavioral, or meet educational goals. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program (IEP) indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the District Program Manager for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager must contact the District Program Manage in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the District Program Manager (DPM) and Central Office.

A. A letter of request for services.

B. Parental signature for consent for evaluation and services.

C. A copy of the Individual Education Program (IEP) that includes:

1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment;

2. Specific services requested, such as residential placement;

3. Length of time for the placement. For example, six months, one school year; and,

4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

A. If the member is being placed outside the state and is eligible for the ALTCS, the AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency (LEA) and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes. When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.

When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the IEP.

Transition to the Community

A. When the child's treatment goals and the IEP exit criteria have been met, the Division, LEA, RBHA, family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.

B. The Division, LEA, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.

C. The Division, LEA and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the LEA and the RBHA shall continue to monitor the child's status in the less restrictive placement. Communication between the Division, the LEA and the RBHA shall continue in order to monitor and support the child's successful integration in the new setting.

Coordination of Care Between The Division And The School System

In addition to the review and annual due dates for the Planning Documents, the Support Coordinator is responsible for ensuring the overall provision of care in coordination of care with other agencies for each member, including educational services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is also important to develop working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school, and participate in the development of the IEP. Coordinating the efforts of the education plan with the Division's Planning Documents can ensure these plans complement each other and provide better care for the member. If the family does not remember to invite the Division staff to the IEP meeting, the school representative should be invited to the Division's Planning Meeting.
When the Division identifies an educational need, the Support Coordinator will take the following steps:

A. Discuss identified need with the family;

B. Within five working days of obtaining the family's agreement, contact the local schoolteacher and/or principal to inquire about the identified educational need;

C. Contact the District Program Administrator/District Program Manager within two working days of contacting the school to request support with their counterpart in the local school district if the teacher and/or principle have not responded;

D. Contact the Division's Central Office within two weeks to request support in coordination with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district;

E. As appropriate, raise the general issue(s) at the Arizona Department of Education (ADDE) through Central Office; and,

F. Follow up with the member or the representative regarding whether or not the need has been/was met.

Discharge Planning

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

A. Member/family/caregiver;

B. Primary care provider/specialist;

C. Discharge Coordinator/Social Worker/Quality Assurance Nurse;

D. Utilization Review Nurse (hospital, Division or Health plan);

E. The Division Discharge Planning Coordinator;

F. The Division Support Coordinator; and;

G. Other Planning Team members, as necessary.

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of ALTCS eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division's District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.
The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an

Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment;

B. Review of discharge orders written by doctor;

C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders;

D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed;

E. Ensure that transportation arrangements have been made;

F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents);

G. The District Nurse or Discharge Planning Coordinator will complete a Utilization Review Nursing Worksheet – Health Care Services, and send copies to the Support Coordinator and Health Care Services (HCS); and,

H. Notification and/or signatures as required on the *Utilization Review Nursing Worksheet* – HCS form:

1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator);

2. District Program Manager or designee (to be notified about all changes of placement);

3. Medical Director (to be notified by HCS of level of care changes); and,

4. The Division Assistant Director/designee (signature also required for placement in a planning document).

Members with Medical Needs

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a members' services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.
The Support Coordinator, District Nurse, and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:

A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator;

B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member's condition and the concerns expressed by the member/family/caregiver; and,

C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, and the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member's discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).

D. If placement is an issue:

1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.

2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.

3. Based on the Planning Documents, the Support Coordinator will work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

E. If the Division is expected to pay for a Planning Document placement, a thorough review is required, including HCS, before any admission is made. All placements in Planning Document(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:

1. In-home supports;

2. Individually Designed Living Arrangement; and,

3. Community based placements, e.g.; Group Home; Child Developmental Home (CDH); or Adult Developmental Home (ADH).

See Division Medical Policy Manual for more information on Planning Document.

A. For those members who are returning to a Planning Document, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.

B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care, and transportation.

C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet* –upon discharge, and send copies to the Support Coordinator and HCS.

D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider, or any other attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division's Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

E. The member's primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member's hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

Members Without Medical Needs

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a Nursing Assessment - HCS to plan and recommend an appropriate level of care;

B. If the member is non-medically involved, the Support Coordinator will:

1. Ensure that training of caregivers has taken place;

2. Assess for and authorize in-home supports as appropriate;

3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems; and,

4. Ensure that follow-up instructions are in place.

C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.

Foster Care Discharge Planning

For all members in foster care, the following discharge planning procedures shall be implemented:

A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a Utilization Review Nursing Worksheet − HCS, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A Nursing Assessment - HCS will be updated/completed to determine home based nursing services and/or placement needs.

B. The District Nurse or Discharge Planning Coordinator must be notified:

   1. Prior to any foster child being admitted to or discharged from a planning document or Nursing Facility (NF).

   2. Prior to any foster child that is medically involved, receiving home based nursing services, or being considered for a change in placement.

C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the *Utilization Review Nursing Worksheet* − HCS, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to a planning document admission, the personal authorization of the Assistant Director (or designee) is required.

D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litems, or other professionals from the juvenile court.

Discharge/Transition of Members with Severe Behavioral Challenges

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within 72 hours. Support Coordinators shall, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

A. Involve staff responsible for contracting with Provider Agencies as soon as possible;

B. Begin the appropriate Planning Process; and,

C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide

reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The Emergency Contact Plan is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the Regional Behavioral Health Authority (RBHA). The Emergency Contact Plan should be kept in an easily accessible place in the setting, but it should never be posted.

The Emergency Contact Plan does not take the place of the Behavior Plan. Begin development of the behavior plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "crisis plan." It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.

541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

REVISION DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-761 et seq, A.R.S. § 15-1181, AMPM 541, Division Operation Policy 417

PURPOSE

This policy outlines how the Division shall develop and maintain collaborative relationships with other government entities that deliver services to Members and their families, ensure access to services, and coordinate care with consistent quality. This policy also outlines how the Division shall provide monitoring and oversight of the Administrative Services Subcontractors (AdSS) in their performance of the coordination with other government agencies.

DEFINITIONS

1. "Adult Recovery Team" or "ART" means a group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and service delivery. At a minimum, the team consists of the Member, the Member's Responsible Person if applicable, advocates if assigned, and a

qualified behavioral health representative. The team may also include the enrolled Member's family, physical health, behavioral health, or social service providers, the Support Coordinator, other agencies serving the Member, professionals representing various areas of expertise related to the Member's needs, or other Members identified by the enrolled Member.

2. “Child and Family Team” or “CFT” means a defined group of individuals that includes, at a minimum, the child and his or her family or Responsible Person, the assigned Support Coordinator, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family or Responsible Person. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, mosques, or other places of worship and faith, agents from other service systems like the Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by

who is needed to develop an effective Planning Document and can therefore expand and contract as necessary to be successful on behalf of the child.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Rapid Response" means a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is dispatched within 72 hours, to assess a child's immediate behavioral health needs, and refer for further assessments through the behavioral health system.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

6. "Service Plan" means a complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the Member in achieving an improved quality of life.

7. "State Placing Agency" means the Department of Juvenile Corrections, Department of Economic Security (DES), Department of Child Safety (DCS), the Arizona Health Care Cost Containment System (AHCCCS), or the Administrative Office of the Court. (A.R.S. §15- 1181(12).

8. "Team Decision Making" or "TDM" means when an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child's safety and where they will live.

POLICY

A. COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

1. The Division shall have policies, protocols, and procedures that describe how the Division coordinates and manages Member care with other governmental entities.

2. The Divisions shall ensure collaboration by participating in the Member's:

   a. Planning Team meetings,

   b. Child and Family Team (CFT) meetings, and

c. Adult Recovery (ART) meetings.

3. The Division shall ensure all required protocols and agreements with State agencies are specified in the provider manuals.

4. The Division shall develop and maintain mechanisms and processes to identify barriers to timely services for Members served by other governmental entities.and work collaboratively with them to remove barriers to Member care and to resolve any Member quality of care concerns.

5. The Division shall work in collaboration with DCS to coordinate Member care.

6. The Division shall coordinate with Tribal Regional Behavioral Health Authorities (TRBHAs) for Members receiving behavioral health services through a TRBHA.

7. The Division shall participate in the Member's Planning Team meetings, CFTs or ARTs to coordinate services for the family and temporary caregivers for Members referred through the Arizona Families F.I.R.S.T. (AFF) program.

8. The Division shall work in collaboration with the Arizona Department of Education and the Member’s school to assist with

resources and referral linkages to help a Member achieve success in school for children with behavioral health needs.

9. The Division shall not be financially responsible for services provided by Local Educational Authorities (LEAs), as specified in AMPM Policy 710, for Members receiving special education services.

10. The Division shall collaborate and coordinate care for Members involved with the following governmental entities as outlined in AMPM Policy 1021 and 1022:

    a. Arizona Department of Corrections (ADOC),

    b. Arizona Department of Juvenile Corrections (ADJC),

    c. Administrative Offices of the Court (AOC), or

    d. County Jails System

B. MONITORING AND OVERSIGHT

1. The Division shall conduct an annual operational review of the AdSS to ensure the AdSS:

    a. Has policies and procedures that describe how Member care is coordinated and managed when other government

entities are involved.

b. Demonstrates evidence of collaborative work with the following:

i. Arizona Department of Child Safety (DCS)

ii. DCS Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) (AFF) Program

iii. Arizona Department of Education (ADE), Schools, or other local Educational Authorities.

iv. Arizona Department of Economic Security (DES) Arizona Early Intervention Program (AzEIP)

v. Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

vi. Courts and Corrections

2. The Division shall conduct quarterly oversight meetings with the AdSS for the purpose of reviewing AdSS performance and addressing any Member access to care concerns.

3. The Division shall review data submitted by the AdSS

demonstrating ongoing compliance monitoring of their network of provider agencies through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:52 PDT)
Anthony Dekker, D.O.

570 BEHAVIORAL HEALTH PROVIDER CASE MANAGEMENT

REVISION DATE: 11/9/2022, 7/3/2015
EFFECTIVE DATE: June 30, 1993
REFERENCES: A.R.S § 36-551; ACOM 407; AMPM Chapter 200; AMPM 320-O; AMPM 570

PURPOSE

The purpose of this policy is to outline requirements for Behavioral Health Provider Case Management services for Division of Developmental Disabilities (Division) members who are Arizona Long Term Care System (ALTCS) eligible.

DEFINITIONS

1. "Assertive Community Treatment Case Management" focuses upon members with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems.
2. "CALOCUS" is a standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family, and guides provision of

ongoing service planning and treatment outcome monitoring in all clinical and community-based settings.

3. "Connective Case Management" means to focus upon members who have largely achieved recovery and who are maintaining their level of functioning. Connective case management involves careful monitoring of the member's care and linkage to service. Caseloads may include both members with an SMI designation as well as members with a general mental health condition or Substance Use Disorder as clinically indicated.

4. "High Needs Case Management" means focus upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvement for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require to be offered the assignment of a high needs case manager are identified as:

    a. Children 0 through five years of age with two or more of the following:

i. Involvement with Arizona Intervention Program (AzEIP), Department of Child Safety (DCS), and/or Division of Developmental Disabilities (DDD), and/or

ii. Out of home residential services for behavioral health treatment within past six months, and/or

iii. Utilization of two or more psychotropic medications, and/or

iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and

b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.

5. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

6. "Provider Case Management" means a collaborative process provided by a behavioral health provider which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through

communication and available resources to promote quality, cost-effective outcomes.

7. "Provider Case Manager" means the person responsible for locating, accessing, and monitoring the provision of services to clients in conjunction with a clinical team.
8. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a client or an applicant for whom no guardian has been appointed.
9. "Substance Use Disorder" means a range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
10. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551
11. "Supportive Case Management" means focus upon members for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance,

support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include members with an SMI designation as well as members with a general mental health condition or substance use disorder as clinically indicated.

POLICY

A. The Division shall ensure that members receive behavioral health case management services in addition to support coordination when requested by the member/responsible person and determined medically necessary for coordination of services. These services may be provided by:

1. A behavioral health provider for members enrolled in subcontracted health plans, or
2. A Tribal Regional Behavioral Health Authority (TRBHA) case manager for members enrolled in the Tribal Health Program.

B. The Division shall cover case management services provided by behavioral health providers involved with a member's care outside of the role of an assigned behavioral health case manager.

C. The Division shall ensure that Provider Case Managers monitor the member's current needs, services, and progress through regular and ongoing contact with the member/responsible person.

D. The DDD Support Coordinator shall participate as part of the Child and Family Team (CFT) or Adult Recovery Team (ART) in determining the frequency and type of contact during the treatment planning process, and adjust as needed, considering clinical need and member preference.

E. The DDD Support Coordinator shall participate as part of the CFT or ART in assessing the intensity level for one of the following types of Provider Case Management:

1. Connective Case Management
2. Supportive Case Management
3. High Needs Case Management
4. Assertive Community Treatment Case Management

F. The Division shall ensure that Provider Case Managers coordinate care on behalf of DDD members to ensure they receive the treatment and support services that will most effectively meet the member's needs by:

1. Coordinating with the member/responsible person, social rehabilitation, vocational/employment and educational providers, supportive housing and residential providers, crisis providers, health care providers, peer and family supports, other state agencies, and natural supports as applicable.
2. Obtaining input from providers and other involved parties in the assessment and service planning process.
3. Providing coordination of the care and services specified in the member's service plan and each provider/program's treatment plan, to include physical and behavioral health services and care.
4. Obtaining information about the member's course of treatment from each provider at the frequency needed to monitor the member's progress.
5. Participating in all provider staffing and treatment/service planning meetings.
6. Obtaining copies of provider treatment plans and entering them as part of the medical record.
7. Providing education and support to members/responsible persons, family members, and significant others regarding the

member's diagnosis and treatment with the member/responsible person's consent.

8. Providing a copy of the member's service plan to other involved providers and involved parties with the consent of the member/responsible person's consent.
9. Providing medication and laboratory information to residential and independent living service providers or other caregivers involved with the consent of the member/responsible person.
10. Coordinating care with the member's assigned care manager as applicable.
11. Utilizing the Behavioral Health Practice Tools located in AHCCCS Medical Policy Manual (AMPM) Chapter 200 for children.
12. In crisis situations:
    a. Identifying, intervening, and/or following up with a potential or active crisis situation in a timely manner,
    b. Providing information, backup, and direct assistance to crisis and emergency personnel, including "on-call" availability of case manager or case management team to the Crisis System

c. Providing follow-up with the member/responsible person after crisis situations, including contact with the member within 24 hours of discharge from a crisis setting,

d. Immediately assessing for, providing, and coordinating additional supports and services as needed to accommodate the individual's member's needs, and

e. Ensuring the member's annual crisis and safety plan is updated as clinically indicated, based on criteria as specified in AMPM Policy 320-O, and readily available to the crisis system, clinical staff and individuals involved in the development of the crisis and safety plan.

G. The Division shall ensure the AdSS develops a provider network with a sufficient number of qualified and experienced behavioral health case managers and meet the following requirements:

1. Behavioral health case managers are available to provide Case Management services to all enrolled members and shall meet the caseload ratios as specified in AMPM 570 Attachment A except as otherwise specified and approved by AHCCCS.

2. All DDD members with a Serious Mental Illness (SMI) designation are assigned to a Provider Case Manager in accordance with A.A.C. R9-21-101, and that all other individual members are assigned a Provider Case Manager as needed, based upon a determination of the individual's member's service acuity needs.
3. Providers are orienting new Provider Case Managers to the fundamentals of providing Case Management services, evaluating their competency to provide Case Management, and providing basic and ongoing training in the specialized subjects relevant to the populations served by the provider, and as specified in ACOM Policy 407.
4. Member/responsible person shall be provided adequate information in order to be able to contact the behavioral health case manager or AdSS for assistance. The AdSS shall also ensure that adequate information is provided to the member/responsible person for what to do in cases of emergencies and/or after hours.

5. Providers have a system of back-up Case Managers in place for members who contact an office when their assigned Provider Case Manager is unavailable and that members be given the opportunity to speak to the back-up provider Case Manager for assistance. The AdSS shall ensure when messages are left for Provider Case Managers that members/responsible persons are called back within two business days.
6. Case Managers are not assigned duties unrelated to member specific case management for more than 10% of their time if they carry a full caseload. (as specified in AMPM 570 Attachment A)
7. Providers establish a supervisor to Provider Case Manager ratio that is conducive to a sound support structure for case managers as per AMPM 570 Attachment A, including establishing a process for reviewing and monitoring supervisor staffing assignments in order to adhere to the AdSS's designated supervisor to Provider Case Manager ratio.
8. Provider Case Manager supervisors have adequate time to train and review the work of newly hired Provider Case Managers as

well as provide support and guidance to established Provider Case Managers.

9. In order to prevent conflicts of interest, ensure that a Provider Case Manager is not:
    a. Related by blood or marriage or other significant relation to a member or to any paid caregiver for a member on their caseload.
    b. Financially responsible for a member on their caseload.
    c. Empowered to make financial or health-related decisions on behalf of a member on their caseload.
    d. In a position to financially benefit from the provision of services to a member on their caseload.
    e. A provider of paid services (e.g., Home and Community Based Services (HCBS), privately paid chores, etc.) for any member on their caseload.

H. The Division shall ensure the AdSS establishes and implements mechanisms to promote coordination and communication between Provider Case Management and AdSS care management teams, with particular emphasis on ensuring coordinated approaches with the

AdSS's Chief Medical Officer (CMO), Medical Management (MM) and Quality Management (QM) teams as appropriate.

I. The Division shall ensure the AdSS submits a Case Management Plan that addresses how the AdSS will collaborate with other Contractors to implement and monitor Provider Case Management standards and caseload ratios for adult and child members, as well as including:

1. performance outcomes,
2. lessons learned, and
3. strategies targeted for improvement, and
4. evaluation of the AdSS's Case Management Plan from the previous year.

J. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

1. Annual Operational Review of each AdSS
2. Review and analyze deliverable reports submitted by the AdSS
3. Conduct oversight meetings with the AdSS for the purpose of:
   a. reviewing compliance,
   b. address concerns with access to care or other quality of care concerns,

c. discuss systemic issues and

d. provide direction or support to the AdSS as necessary

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 11:06 PDT)
Anthony Dekker, D.O.

580 BEHAVIORAL HEALTH REFERRAL PROCESS

REVISION DATE: 6/15/2022

EFFECTIVE DATE: August 4, 2021

REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) with regard to ensuring that eligible ALTCS members enrolled in a DDD Health Plan, including the Tribal Health Program with behavioral health and substance use disorders, can gain prompt access to behavioral health services. For Division members enrolled in other AHCCCS health plans (i.e., targeted support coordination members), the Support Coordinator shall coordinate with the member's AHCCCS Complete Care plan for behavioral health services.

The Division delegates the responsibility to Administrative Services Subcontractor (AdSS) for the implementation of behavioral health services, whose contract includes this requirement, for eligible members enrolled in a DDD Health Plan. (Refer to AdSS Medical Policy 580.) The Division remains responsible for support coordination, care coordination for members enrolled in the Tribal Health Program and oversight of the AdSS. (Refer to Division Medical Policy 1620-G related to behavioral health referrals and service coordination.)

DEFINITIONS

Assessment means the ongoing collection and analysis of a member's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the member's planning

document is designed to meet the member's (and family's) current needs and long-term goals.

Intake means the initial evaluation and collection, by appropriately trained staff, of basic demographic information and preliminary identification of the member's needs.

Referral means, for purposes of this policy, a verbal, written, telephonic, electronic, or in-person request for behavioral health services.

Responsible Person means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S § 36-551.

Serious Mental Illness (SMI) Determination means a determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

POLICY

A. GENERAL REQUIREMENTS FOR BEHAVIORAL HEALTH SERVICES REFERRAL

1. A referral may be made, but is not required, to initiate behavioral health services. A member/responsible person may directly outreach a behavioral health provider, the Division, or their health plan, to initiate services or to identify a contracted service provider. If behavioral health services are not available within the service array of an existing provider, a referral may

be made by any of the following:

a. A member or the member's responsible person,
b. The Division,
c. DDD subcontracted health plan,
d. Primary care provider (PCP),
e. Other providers within their scope of practice,
f. Hospital,
g. Jail,
h. Court,
i. Probation or parole officer,
j. Tribal entity,
k. Indian Health Services/638 Tribally operated facility,
l. School,
m. Other governmental or community agency, and
n. Members in the legal custody of the DCS, the out-of-home placement as specified in A.R.S. §8-512.01 and Division Operations Policy 449.

2. TRBHA responsibilities regarding referrals are specified in the TRBHA Intergovernmental Agreements (IGAs).

3. To facilitate timely access to behavioral health services, the Division shall ensure an effective referral process is in place for members seeking or screened as at-risk for needing behavioral health services including but not limited to general mental health/substance use services, members determined to have an SMI, and those seeking an SMI designation. The referral process shall include:

a. Engaging with the member/responsible person to communicate the process for making referrals, including

self-referrals, ensuring that the referral process maximizes member and family voice and a choice of service providers, as well as the allowance of THP members to see any AHCCCS registered provider;

b. Referrals are accepted for behavioral health services 24 hours a day, seven days a week. The processing of referrals shall not be delayed due to missing or incomplete information. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

c. Sufficient information is collected through the referral process to:

   i. Assess the urgency of the member's needs;

   ii. Track and document the disposition of referrals to ensure subsequent initiation of services. The Division shall ensure the AdSS comply with timeliness standard specified in AdSS Operational Policy 417; and

   iii. Ensure members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs;

d. Information or documents collected in the referral process are kept confidential and protected in accordance with applicable federal and state statutes, regulations, and

policies.

e. Providers offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

B. REFERRALS FOR INDIVIDUALS ADMITTED TO A HOSPITAL

1. The Division shall ensure referrals involving members admitted to a hospital, who are identified as in need of behavioral health services, are responded to as follows:

   a. Upon notification of a member not currently receiving behavioral health services, the Division shall ensure a referral is made to a provider agency within 24 hours.

   b. The Division shall ensure the AdSS' provider agencies attempt to conduct a face-to-face intake evaluation with the member within 24 hours of referral and the evaluation occurs prior to discharge from the hospital.

   c. For members already receiving behavioral health services, the Division shall ensure coordination, transition, and discharge planning activities are completed in a timely manner as specified in Division Medical Policy 1021.

   d. TRBHA responsibilities regarding referrals are outlined in the TRBHA Intergovernmental Agreements.

C. DIVISION OVERSIGHT OF AdSS

1. The Division shall complete an Annual Operational Review of each AdSS in the following areas:

a. The AdSS has policies and procedures to ensure members receive behavioral health services.

b. The AdSS ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.

c. The AdSS ensures that training and education is provided to PCPs regarding the behavioral health referral process.

d. The AdSS informs PCPs of the ability and process to directly refer members with suspected diagnosis of autism or other DDD eligible diagnoses directly to a specialized Autism Spectrum Disorder, Cognitive/Intellectual Disability or other DDD qualifying diagnosing provider. For the purpose of eligibility, refer to the Division's Eligibility Policy 200-G and 200-H for a list of diagnostic and functional criteria.

e. The AdSS documentation reflects evidence that medically necessary behavioral services were determined by a qualified behavioral health professional.

f. Review and analyze deliverable reports submitted by the AdSS.

g. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance; address concerns with access to care or other quality of care concerns; discuss systemic issues and provide direction or support to the AdSS as

necessary.

h. Ensure the AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:35 PDT)
Anthony Dekker, D.O.

590 BEHAVIORAL HEALTH CRISIS SERVICES AND CARE COORDINATION

EFFECTIVE DATE: January 18, 2023
REFERENCES: AHCCCS Contract

PURPOSE

This policy describes the requirements related to the behavioral health Crisis system for Arizona Long Term Care System (ALTCS) eligible members.

DEFINITIONS

1. "Crisis" means an acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. A Crisis is self-defined and determined by the individual experiencing the situation. An individual is in Crisis if the individual finds they lack the skills or are unable to cope with a situation or event that is impacting them.
2. "Crisis Services" means services that are community based, recovery-oriented, and member-focused that shall work to stabilize members as quickly as possible so as to assist them in returning to their baseline of functioning.

3. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. The Division shall ensure medically necessary services and care are provided to members following a Crisis episode or discharge from a crisis stabilization setting.

B. The Division shall be financially responsible for services after the initial 24 hours of a Crisis episode, which is covered by the AHCCCS Complete Care Regional Behavioral Health Authority (ACC-RBHA), or discharge from a Crisis stabilization setting, whichever occurs first.

C. The Division shall ensure emergency transportation from Crisis receiving facilities is covered as a health plan benefit.

D. The Division shall ensure non-emergent transportation from Crisis receiving facilities is covered as a health plan benefit for members not

residing in community residential settings and Intermediate Care Facilities for the Intellectually Disabled.

E. The Division shall ensure community residential settings and Intermediate Care Facilities for the Intellectually Disabled provide non-emergent transportation from Crisis receiving facilities for members residing in those settings.

F. The Division shall publicize Crisis Services, including the statewide Crisis phone number, prominently on their websites, in their resource directories, and on the following relevant member and community materials:

1. Division website,
2. Member handbook, and
3. Member identification cards.

G. The Division shall ensure care coordination occurs between:

1. The member's health plan;
2. Behavioral health provider;
3. The Division;
4. Crisis providers; and
5. The member, if applicable.

H. The Support Coordinator shall follow up with the Responsible Person within two business days from receiving the focus global notification to gather information regarding what event occurred before the Crisis line was called and assess the following:

1. Whether additional support is needed from either the Division or behavioral health provider.
2. Whether the member is receiving the appropriate behavioral health services and:
    a. Make a referral within one business day, if needed; or
    b. Advocate if additional behavioral health services are needed.

I. The Support Coordinator shall:

1. Ensure all planning team members and/or Child and Family Team/Adult Recovery Team are aware of recent contact with behavioral health Crisis services.
2. Coordinate care with the planning team and/or Child and Family Team/Adult Recovery Team as needed to:
    a. Verify medications are taken as prescribed,

b. Verify the member is currently enrolled with a behavioral health provider,

c. Assess for additional behavioral health services, and

d. Ensure the member has a Crisis plan and/or update plan for current needs.

3. Request assistance from the District Behavioral Health Complex Care Specialist as needed.

4. Submit a referral to the Division's Behavioral Health Advocate as needed.

5. Request assistance from the District Nurse if medical concerns are presented.

6. Complete a referral for a Care Manager through the member's ALTCS health plan as needed.

J. The Division shall ensure the Administrative Services Subcontractors (AdSS) develop policies establishing post-Crisis care coordination expectations that provide the following:

1. Transfer of medical records of services received during a Crisis episode, including prescriptions.

2. Tracking of admission, discharge, and re-admissions, including admission setting.
3. Requirements for follow-up directly with the individual, within 72 hours, when discharged from a Crisis setting.
4. Engagement of peer and family support services when responding to post-Crisis situations.
5. The provision of ongoing care is done in an expedient manner in accordance with ACOM Policy 417.

K. The Division shall ensure the AdSS regularly evaluates post-Crisis care coordination activities and work to improve internal and external collaboration efforts. Care coordination activities shall include use of Health Information Technology, as available, to improve member outcomes.

L. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

1. Annual Operational Review of each AdSS,
2. Review and analyze deliverable reports submitted by the AdSS, and
3. Conduct oversight meetings with the AdSS for the purpose of:

a. Reviewing compliance,

b. Addressing concerns with access to care or other quality of care concerns,

c. Discussing systemic issues, and

d. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Jan 13, 2023 11:13 MST)
Anthony Dekker, D.O.

610 AHCCCS PROVIDER QUALIFICATIONS

EFFECTIVE DATE: November 17, 2017
REFERENCES: AHCCCS Medical Policy Manual Exhibit 610-1

All providers of services that are covered by the Division of Developmental Disabilities must:

A. Register with AHCCCS, which requires signing the Provider Participation Agreement or Group Biller Participation Agreement that includes all federal and state requirements as applicable.

B. Comply with all federal, state, and local laws, rules, regulations, executive orders, and agency policies governing performance of duties under the contract.

C. Sign and return attestations, found on the Provider Registration section of the AHCCCS website, that apply to their individual practices or facilities.

D. Meet AHCCCS requirements for professional licensure, certification, or registration, including current Medicare certification.

E. Complete all applicable registration forms.

Institutional and other designated providers are required to submit an enrollment fee (see AHCCCS Medical Policy Manual Exhibit 610-1).

Specific provider types require an AHCCCS Office of the Inspector General (AHCCCS-OIG) site visit prior to enrollment, and they are subject to unannounced post enrollment site visits (see AHCCCS Medical Policy Manual Exhibit 610-1).

AHCCCS Provider Registration Materials

AHCCCS-OIG Provider Registration materials are available on the AHCCCS web site. On the AHCCCS website, click on the “Plans/Providers” tab. In the resulting screen, click on the “New Providers” link and, in the resulting dropdown menu, click on the “Provider Reenrollment” link. The forms can be completed on the AHCCCS website, but they must be submitted by fax or mail.

AHCCCS Provider Types

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician) established by AHCCCS. The AHCCCS-OIG “Provider Registration” section on the AHCCCS website will help providers to identify the most appropriate provider type, based on the provider's license/certification and other documentation.

Refer to the AHCCCS website for additional information regarding provider registration requests.

680-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

REVISION DATE: 11/15/23, 12/21/22, 9/25/19, 4/1/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: 42 CFR 4 83.100 – 438.138, 42 CFR 447, 42 CFR 483.20

PURPOSE

This policy outlines the Division of Developmental Disabilities (Division) role in the Pre-Admission Screening and Resident Review (PASRR) requirements with the Intergovernmental Agreement.

DEFINITIONS

1. "Determination" means the outcome of the Level II assessment which ensures the nursing facility placement is, or continues to be, appropriate, and that services provided to individuals with a mental illness, intellectual disability, or related condition meet the individual's needs, including the need for specialized services.

2. "Health Care Decision Maker (HCDM)" means an individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully

authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8514.05, 36-3221, 36-3231 or 36-3281.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Resident Review" means a subsequent Level II assessment and determination for existing nursing facility residents, triggered whenever an individual undergoes a significant change in status and that change has a substantial impact on their functioning as it relates to their mental illness/intellectual disability status.

5. "Significant Change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both (42 CFR 48 3.20).

POLICY

A. DIVISION REQUIREMENTS

1. The Division shall conduct Level II PASRR assessment for individuals suspected to have an Intellectual Disability (ID) or a related condition:

    a. Within nine business days from the date the completed Level I PASRR screening is received.

    b. Within five business days from the date the completed Level I PASRR screening is received when the Member is awaiting discharge from a hospital.

2. The Division shall ensure upon completion of Level II PASRR assessment, a Letter of Determination is sent to the following when applicable:

    a. Arizona Health Care Cost Containment System (AHCCCS);

    b. Social worker from the referring facility;

    c. Member and/or HCDM;

    d. Attending physician;

e. Support Coordinator; and

f. Social worker from a discharging facility.

B. RESIDENT REVIEW

The Division shall review resident review requests for individuals experiencing a significant change in condition within nine business days of the completed PASRR Level I screening being received.

C. ADMINISTRATIVE REVIEW PROCESS

1. The Division shall ensure an administrative review is provided for:

   a. Members to appeal a notice of intent to discharge or transfer the Member, and

   b. Members who have been adversely affected by a PASRR Determination in the context of:

      i. Preadmission screening, or

      ii. Annual resident review.

2. The Division shall ensure an appeals process is provided

as outlined in §483.15(h) and §431(e).

3. The Division shall ensure the following information is provided to the Member when filing an appeal:

   a. Statement of the Member's appeal rights;

   b. Name, address and telephone number of the entity receiving the request;

   c. How to obtain an appeal form;

   d. Assistance in completing and submitting the form for an appeal hearing request.

Signature of Chief Medical Officer: Anthony Dekker (Nov 9, 2023 11:53 MST)
Anthony Dekker, D.O.

700 School Based Claiming For Medicaid

REVISION DATE: 9/15/2014
EFFECTIVE DATE: June 30, 1994

The School Based Claiming Program through Arizona Health Care Cost Containment System (AHCCCS) covers both school-age children who are Medicaid Long Term Care eligible, and members supported by the Division's Targeted Support Coordination. The member must be at least three years of age but younger than 22 years of age, and have been determined by the school to be eligible for special education and related services. (See AHCCCS Medical Policy Manual Chapter 700.)

910 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM SCOPE

REVISION DATE: 10/11/2023, 12/07/2022, 10/01/2020, 8/1/2018, 7/15/2016

EFFECTIVE DATE: May 27, 2016

REFERENCES: 42 CFR Part 438, 42 CFR 438.2, 42 CFR 438.208, 42 CFR 438.242, 42 CFR 438.310(c)(2), 42 CFR 438.320, 42 CFR 438.330, AMPM 910, AMPM 900,

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) regarding the administration, management, and implementation of the Quality Management and Performance Improvement (QM/PI) Program. This policy sets forth roles and responsibilities of the Division to provide oversight and ongoing Evaluation of the Administrative Services Subcontractors' (AdSS) compliance with QM/PI Program requirements.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:
    a. Claims processing, including pharmacy claims,
    b. Pharmacy Benefit Manager (PMB),
    c. Dental Benefit Manager,
    d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),
    e. Management Service Agreements,
    f. Medicaid Accountable Care Organization (ACO),
    g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and
    h. Comprehensive Health Plan (CHP) and DDD Subcontracted Health Plan.

A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Corrective Action Plan " or "CAP" means a written work plan that identifies the root cause(s) of a deficiency. The CAP is made up of goals and objectives; actions and tasks to be taken to facilitate an expedient return to compliance; methodologies to be used to accomplish CAP goals and objectives; and staff responsible to carry out the CAP within the established timelines.
3. "Evaluation" or "Evaluating" means the process used to examine and determine the level of Quality or the progress toward improvement of Quality and performance related to Division service delivery systems.
4. "Executive Body" means ADES Director, ADES Deputy Director and ADES Chief Compliance Officer.
5. "Health Information System" means the data system that collects, analyzes, integrates, and reports data and can achieve

the objectives of 42 CFR Part 438. The system provides information in the following areas: utilization; claims; grievances and appeals; and disenrollments for other than loss of Medicaid eligibility (42 CFR 438.242).

6. "Long Term Services and Supports" or "LTSS" means services and supports provided to Members of all ages who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider- owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).
7. "Member" means the same as "Client" as defined in A.R.S.§36-551.
8. "Monitoring" means the process of auditing, observing, Evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.

9. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services (42 CFR 438.320).
10. "Performance Improvement Project" or "PIP" means a planned process of data gathering, Evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
11. "Provider" means any individual or entity that contracts with the AdSS for the provision of covered services, or ordering or referring for those services to Members enrolled in an AdSS' health plan, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.
12. "Quality" as it pertains to external review, means the degree to which a contractor described in 42 CFR 438.310(c)(2) increases the likelihood of desired Outcomes of its Members

through:

a. Its structural and operational characteristics.

b. The provision of services that are consistent with current professional, evidenced-based knowledge.

c. Interventions for performance improvement (42 CFR 438.320).

POLICY

A. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM OVERVIEW

1. The Division shall include the following elements in the QM/PI Program:

   a. Performance Improvement Projects (PIPs),

   b. Collection and submission of performance measurement data,

   c. Mechanisms to detect both under and overutilization of services, and

d. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.

2. The Division shall include the following elements for Long-Term Services and Supports (LTSS) in the QM/PI program:

a. Mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including:

i. Assessment of Care between care settings; and

ii. A comparison of services and supports received with those set forth in the member's treatment or service plan, if applicable, and

b. Participation in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements of the State for home and community-based waiver programs.

B. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM COMPONENTS

The Division shall adhere to the following QM/PI Program requirements:

a. Demonstrate that Members' rights and responsibilities are defined, implemented, and monitored;

b. Ensure that medical records and communication of clinical information for each member:

   i. Reflect all aspects of member care, including ancillary and behavioral health services; and

   ii. Are supported by policies and procedures for electronic signatures when electronic documents are utilized;

c. Conduct temporary or provisional, initial, and re-credentialing processes for individual and organizational providers in accordance with AMPM Policy 950;

d. Track and trend Quality of Care (QOC) concerns, service issue resolutions, and grievance and appeals that meets the standards as specified in AMPM Policy 960, 42 CFR 438.400, and 42 CFR 438.242 et seq.;

e. Develop and implement planned activities to meet or exceed AHCCCS-mandated Performance Measure

Performance Standards (PMPS), as specified in AHCCCS Contract and required by AMPM Policy 970, and PIP goals, as required by AMPM Policy 980;

f. Implement processes to review and Evaluate its quality improvement data for accuracy, completeness, logic, and consistency as well as trend quality improvement data to identify potential areas for improvement;

g. Evaluate performance measure and PIP results based on a number of demographics in order to reduce health disparities across demographics, to the extent practical;

h. Identify goals and objectives and implement interventions that are meaningful, specific, and applicable to the population(s) served;

i. Ensure ongoing communication and collaboration with other functional areas of the Division;

j. Demonstrate the obtainment and incorporation of input in matters related to program activities from:

   i. AHCCCS Members,

ii. Stakeholders,

iii. Advocates; and

iv. Contracted providers;

k. Monitor the quality and coordination between physical and behavioral health services, with procedures to ensure timely updates occur between Primary Care Physicians (PCPs) and behavioral health providers regarding a member's change in health status that shall include:

i. Diagnosis of chronic conditions,

ii. Changes in physical or behavioral health condition or diagnosis,

iii. Support for the petitioning process, if applicable,

iv. Transition to or from an ACC-RBHA, based on Serious Mental Illness (SMI) designation, when appropriate;

l. Promote timely engagement and appropriate service levels for adult Members, as well as enrolled youth and caregivers;

m. Identify, monitor, and implement interventions for High Needs/High Cost (HN/HC) Members to ensure appropriate and timely service provision for behavioral or physical health needs through developing processes to:

   i. Monitor appropriate use of methodologies for screening and identification of high needs adult Members; and

   ii. Maintain policies for Monitoring and documentation of ongoing implementation for AHCCCS review;

n. Identify standards for adults with an SMI diagnosis for all levels of service intensity;

o. Establish mechanisms to connect Members and families to family run organizations;

p. Provide training and Monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools including:

   i. Assertive Community Treatment,

   ii. Supported Employment,

iii. Supportive Housing; and

iv. Consumer Operated Services;

q. Provide training of clinical and general staff on eligibility and use of services available for substance use prevention or treatment through funds available for individuals that are Non-Title XIX/XXI eligible, and as specified in AMPM Policy 320-T1.

r. Promote Evidence Based Practices in Substance Use Disorder (SUD) Treatment Services;

s. Develop a process to identify and refer youth and young adults to the behavioral health system when identified as having a diagnosed SUD;

t. Ensure implementation and completion of American Society of Addiction Medicine (ASAM) Criteria, utilizing the most current edition at the time of service in:

i. SUD assessments,

ii. Service planning,

iii. Level of care placement, and

iv. Monitoring fidelity of ASAM implementation in accordance with AHCCCS directed phased in approach;

u. Ensure AdSS has a process to increase and promote physical health care providers' knowledge of health-related topics including substance use screening, overdose reversal medications, and Medication Assisted Treatment (MAT) options available to Members;

v. Promote suicide prevention following the Zero Suicide Model to support the identification and referral of Members in need of behavioral health or crisis services considering of the following:

i. Community Members;

ii. Physical health providers;

iii. Behavioral health providers;

iv. Interested stakeholders; and

v. Agencies that serve individuals at increased risk for suicide (Veterans, individuals with Posttraumatic

Stress Disorder (PTSD), Native Americans, middle aged white males, Members of the Lesbian, Gay, Bisexual and/or Transgender Queer/Questioning (LGBTQ+) community, foster care, those age 65 and older, juvenile justice, and women post-partum);

w. Identify Veteran and service member enrollment within the behavioral health system to initiate referrals when behavioral health needs are identified;

x. Implement policies and procedures that require:

i. Providers to report the following incidents to the proper authorities as well as the Division, as soon as they become aware of the incident:

1) Incidents of abuse,

2) Neglect,

3) Injuries,

4) Exploitation,

5) Healthcare acquired conditions, and

6) Unexpected death.

ii. Providers to submit Incident, Accident, and Death reports to the Division as specified in 9 A.A.C. 10, AMPM Policy 960, and AMPM Policy 961;

y. Implement policies and procedures that:

i. Require providers to monitor and trend all suicides or suicides attempts;

ii. Ensure that all providers recognize signs and symptoms of suicidal ideation and at-risk behaviors for children and adults regardless of mental health status; and

iii. Ensure AdSSs identify requirements for care coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a physical health or behavioral health practitioner witnesses a patient with:

1) Suicidal ideation,

2) At-risk behaviors, or

3) Significant change in either the behavioral or physical health condition;

z. Develop a process to ensure a Health Risk Assessment (HRA) is conducted within 90 days of a new Member's effective enrollment date that consists of the following:

i. A "best effort" attempt is made to conduct an initial HRA of each member's health care needs;

ii. Follow up on unsuccessful attempts to contact a Member is made within 90 days of the effective date of enrollment;

iii. Each attempt is documented;

iv. Results of HRAs are used to identify individuals at risk for, or with special health care needs and coordinate care:

1) Refer to AMPM Policy 1620-A and AMPM Exhibit 1620-1 to obtain time frames for which ALTCS case managers shall have an initial contact with newly enrolled ALTCS Members; and

2) Refer to AMPM Policy 580 and ACOM Policy 417 to obtain time frames for which the Division shall have initial contact with referred Members for behavioral health services.

aa. Continuity of care and integration of services utilizing:

i. Programs for care coordination that include coordination of covered services with community and social services, generally available through contracted or non-contracted providers within the Division's service area;

ii. Monitoring of referral activities for both the PCP and the behavioral health provider during referral to, coordination of care with, and transfer of care between the PCP and the behavioral health provider;

iii. Monitoring to ensure that when a member is transitioning from the physical health provider to the behavioral health provider, or vice-versa, that bridge

medications are provided as specified in AMPM Policy 310-V and AMPM Policy 520;

iv. Monitoring of PCP's coordination of care with the Behavioral Health Medical Professional (BHMP), when PCPs are providing medical management services for the treatment of:

1) Mild depression;

2) Anxiety;

3) Attention Deficit Hyperactivity Disorder (ADHD); and

4) SUD, or Opioid Use Disorder (OUD) for Members with an SMI designation.

v. Monitoring to ensure that medication management by the PCPs is given within the PCP's scope of practice;

vi. Monitoring when PCP is providing treatment of mild depression, anxiety, ADHD, SUD, or OUD to ensure that medications are not contraindicated, based on

member's SMI designation or other behavioral health condition or functional status;

vii. Monitoring when a PCP is providing medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP and Division that the member should receive care through the behavioral health system for Evaluation or continued medication management services, the Division's subcontracted providers shall assist the PCP with the coordination of the referral and transfer of care.

viii. Monitoring documentation of the care coordination activities and transition of care in the member's medical record from the PCP and the involved behavioral health provider;

ix. Utilizing Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), in accordance with A.R.S. § 36-2606;

x. Monitoring of the behavioral health provider's referral to, coordination of care with, and transfer of care to PCP, as well as usage of Arizona's CSPMP, in accordance with A.R.S. § 36-2606; and

xi. Monitoring of coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a physical or behavioral health practitioner witness a patient with suicidal ideation or at-risk behaviors.

bb. Implement policies and procedures that specify:

i. The process for Members selecting, or the AdSS assigning, a PCP who is formally designated as having primary responsibility for coordinating the Members overall health care. The PCP shall coordinate care for the member including coordination with the BHMP or Behavioral Health Professional (BHP), and

ii. Processes for provision of appropriate medication monitoring for Members taking antipsychotic medication (per national guidelines):

1) Monitoring metabolic parameters for lithium, valproic acid, carbamazepine,

2) Renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and involuntary movement disorders,

3) Provision of medication titration according to, drug class requirements and appropriate standards of care:

a) The circumstances under which services are coordinated by the Division, the methods for coordination, and specific documentation of these processes;

b) Specify services coordinated by the Division's Disease Management Unit; and

c) The requirements for timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940.

cc. Implement measures to ensure that Members:

i. Are informed of specific health care needs that require follow-up;

ii. Receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

iii. Are informed of their rights and responsibilities including, but not limited to the responsibility to adhere to ordered treatments or regimens.

dd. Develop and implement procedures for Members with special health care needs, as defined in the AHCCCS Contract, including:

i. Identifying Members with special health care needs, including those who may benefit from disease management;

ii. Ensuring an assessment by an appropriate health care professional of ongoing needs of each Member identified as having special health care need(s) or condition(s);

iii. Identifying medical procedures or behavioral health services, as applicable to address or monitor the need(s) or condition(s);

iv. Ensuring adequate care coordination among providers, including but not limited to, other Contractors or insurers and behavioral health providers, as necessary;

v. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs; and

vi. Implement processes and measures to ensure that Members receive Special Assistance, based on criteria as specified in AMPM Policy 320-R.

ee. Maintain a health information system that collects, integrates, analyzes, validates, and reports data necessary to implement its QM/PI Program (42 CFR 438.242). Data elements shall include:

i. Member demographics and designations;

ii. Encounter data and provider characteristics;

iii. Services provided to Members; and

iv. Other information necessary to guide the selection of, and meet the data collection requirements for:

1) Performance measures;

2) PIPs; and

3) QM/PI Program oversight.

ff. Include requirements, either in the AHCCCS Contract or as an extension of the AHCCCS Contract, for practitioners and providers to cooperate with quality improvement activities

and allow the Division to utilize their performance measure data.

gg. Ensure the inclusion of the following requirements related to data integrity:

i. Information and data received from providers is accurate, timely, and complete;

ii. Reported data is reviewed for accuracy, completeness, logic, and consistency, and the review and Evaluation processes used are clearly documented;

iii. Information that is rejected shall be tracked to ensure errors are corrected and the data is resubmitted and accepted; and

iv. Corrective actions are implemented with providers and vendors when data utilized for implementing and maintaining its QM/PI Program received from providers and vendors is not accurate, timely, or

complete, including data necessary to calculate and report performance measures.

hh. Results of the Division's quality improvement data review, analysis, reporting, and Evaluation are shared with Division staff and stakeholders, with internal corrective actions implemented when self-identified concerns and performance deficiencies are identified.

ii. Division staff and providers are kept informed of the following:

i. QM/PI Program requirements, activities, updates, or revisions;

ii. Study and PIP results;

iii. Performance measures and results;

iv. Utilization data; and

v. Profiling data results.

jj. All member and provider information are protected by Federal and State law, regulations, or policies is kept confidential; and

kk. Maintenance of records and documentation as required under State and Federal law.

ll. All QM/PI Program Components shall be supported through the development, implementation, and maintenance of policies and procedures.

C. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE STRUCTURE AND OVERSIGHT

1. The Division's QM/PI Program shall be administered through a clear and appropriate administrative structure that maintains the ultimate responsibility for the QM/PI Program.
2. The QM/PI Unit shall conduct all work of the QM/PI Program within the QM/PI Unit, adhering to requirements as specified in the AHCCCS Contract and AMPM Chapter 900.
3. The Division shall require that the Division's administrative structure for its QM/PI Program adheres to requirements of this section, which specify the roles and responsibilities of the following:
   a. The governing or policy-making body;

b. The Chief Medical Officer (CMO) or designated Medical Director, and the local DDD Assistant Director;

c. The QM/PI Committee;

d. The Peer Review Committee;

e. QM/PI Program Staff;

f. Delegated Entities; and

g. The Contractor's executive management.

4. The Executive Body and Executive Leadership Team (ELT) shall:

a. Oversee and be accountable for the QM/PI Program,

b. Review the QM/PI Program Plan, inclusive of the Work Plan and Work Plan Evaluation, and any applicable updates related to changes in the QM/PI Program scope prior to submission to AHCCCS; and

5. The Executive Body and Executive Leadership Team (ELT) shall:

a. Review and approve the QM/PI Program Plan, as demonstrated via an attestation of approval by the Executive Body and Executive Leadership Team (ELT);

b. Formally Evaluate and document the effectiveness of its QM/PI Program strategy and activities, at least annually, as demonstrated via an attestation of approval by the Executive Body and Executive Leadership Team (ELT);

6. The Division's Chief Medical Officer (CMO) and Division's Assistant Director shall:

   a. Oversee the implementation of the QM/PI Program Plan; and

   b. Have substantial involvement in the:

      i. Implementation;

      ii. Assessment; and

      iii. Resulting improvement of QM/PI Program activities;

   c. The CMO shall approve and sign all QM/PI policies.

7. The QM/PI Committee shall have an identifiable and structured QM/PI Committee within the state of Arizona that is responsible for QM/PI Program functions and responsibilities.

   a. Membership shall include:

      i. The CMO, serving as the chairperson:

1) The CMO may designate the local Associate Medical Director as their designee only when the CMO is unable to attend the meeting; and

2. The DDD Assistant Director may be identified as the co-Chair of the QM/PI Committee.

ii. The QM/PI Manager(s):

1) Representatives from the functional areas within the Division;

2) Contracted or affiliated providers serving AHCCCS Members; and

3) Clinical representatives of both the Division and the provider network.

b. The QM/PI Committee shall ensure that each of its Members are aware of the requirements related to confidentiality and conflicts of interest by having either:

i. Signed statements on file; or

ii. QM/PI Committee sign-in sheets with requirements noted.

c. The QM/PI Committee shall conduct meetings, at minimum, on a quarterly basis:

   i. The frequency of committee meetings shall be sufficient to monitor all program requirements and to monitor any required actions; and

   ii. The Division shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation.

d. The QM/PI Committee shall:

   i. Review the QM/PI Program objectives, policies, and procedures as specified in the AHCCCS Contract;

   ii. Update policies when processes or activities are changed substantially; and

   iii. Make available upon request for review by AHCCCS QM and/or Quality Improvement (QI) Teams, the QM/PI policies, procedures, and any subsequent modifications.

e. The QM/PI Committee shall also:

i. Review, Evaluate, and approve any changes to the QM/PI Program Plan;

ii. Develop procedures for QM/PI Program responsibilities and clearly document the processes for each QM/PI Program function and activity;

iii. Develop and implement procedures to ensure that Division staff and providers are informed of the most current QM/PI Program requirements, policies, and procedures; and

iv. Develop and implement procedures to ensure that providers are informed of information related to their performance;

f. The QM/PI Committee shall ensure meeting minutes clearly document discussions of the following:

i. Identified issues;

ii. Responsible party for interventions or activities;

iii. Proposed actions;

iv. Evaluation of the actions taken;

v. Timelines including start and end dates; and

vi. Additional recommendations or acceptance of the results, as applicable.

8. The Division shall have a peer review process with the purpose of improving the QOC provided to Members by both individual and organizational providers.

9. The Division shall ensure the peer review scope includes cases where there is evidence of deficient quality or the omission of the care or service provided by a physical or behavioral health care provider whether delivered in or out of state.

10. The Division shall define the peer review scope through specific policies and procedures which address the following requirements:

a. The Division shall not delegate functions of peer review to other entities;

b. The Peer Review Committee is scheduled to meet at least quarterly, or more frequently, as needed;

c. The Peer Review Committee may carry out activities as a stand-alone committee or in an executive session of the Division's QM Committee;

d. The Peer Review Committee consists of:

   i. The Division's CMO as Chair;

   ii. Contracted medical providers from the community that serve AHCCCS Members; and

   iii. Contracted behavioral health providers from the community that serve AHCCCS Members.

e. The Peer Review Committee also includes:

   i. Providers of the same or similar specialty in review and recommendation of individual peer review cases.

   ii. Peers of the same or similar specialty through external consultation, if the specialty being reviewed is not represented on the Division's Peer Review Committee;

f. Peer Review Committee Members:

i. Shall sign a confidentiality and conflict of interest statement at each Peer Review Committee meeting, electronic signature is permissible; and

ii. Shall not participate in peer review activities if they have a direct or indirect interest in the peer review outcome;

g. The Peer Review Committee shall Evaluate referred cases based on all information made available through the QM process;

h. The Peer Review Committee shall make recommendations to the Division's CMO or their designee, determining appropriate action.

i. The CMO or their designee shall implement actions recommended by the Peer Review Committee. Adverse actions taken as a result of the Peer Review Committee shall be reported to AHCCCS QM Team as specified in the AHCCCS contract;

j. The Peer Review Committee shall make recommendations to the Division's CMO or their designee regarding initiation of referrals for further investigation or action to:

   i. Division of Child Safety (DCS);

   ii. Adult Protective Services (APS);

   iii. Arizona Department of Health Services (ADHS) Licensure Unit;

   iv. The appropriate regulatory agency or board; and

   v. AHCCCS.

k. The Peer Review Committee shall notify the organizations listed in the previous section when the Committee determines care was not provided according to the medical community standards:

   i. To the regulatory agency as soon as possible, no later than 24 hours after the determination; and

   ii. Verbally or electronically, email or online, as determined by the specific organization(s) guidelines.

l. The Division shall develop a process to timely report the concern to the appropriate regulatory agency;

m. The Peer Review Committee shall maintain confidentiality with all information used within the peer review process, keeping reports, meetings, minutes, documents, recommendations, and participants confidential except for when implementing recommendations made by the Peer Review Committee;

n. The Peer Review Committee shall make documentation available upon request to AHCCCS for purposes of QM, Monitoring, and oversight;

o. The Peer Review Committee shall maintain high-level peer review summaries as part of the original QOC file,

p. The Division shall demonstrate:

    i. How the peer review process is used to analyze and address clinical issues;

    ii. How providers are made aware of the peer review process; and

iii. How providers are made aware of the procedure for grieving peer review findings.

q. Matters appropriate for peer review shall be outlined in the Division's Peer Review Charter.

11. The QM/PI Program shall have local personnel to carry out the functions and responsibilities specified in AMPM Chapter 900 in a timely and competent manner, with QM/PI positions performing work functions related to the AHCCCS Contract reporting directly to the local CMO and the CEO.

12. The Division is responsible for AHCCCS Contract performance, whether or not subcontractors or delegated entities are used. As part of the QM/PI Program Staffing requirements, the Division shall:

a. Maintain an organizational chart that shows the reporting relationships for QM/PI Program activities and the percent of time dedicated to the position for each specific line of business:

i. The QM/PI Program organizational chart shall be maintained and demonstrate the current reporting structures, including the number of full time and part time positions, staff names, and responsibilities;and

ii. This chart shall also show direct oversight of QM/PI Program activities by the local CMO.

b. Ensure all staff are trained on the process for referring suspected QOC concerns to the QM Team:

i. During employee orientation, no later than 30 days after the date of hire; and,

ii. At a minimum, annually thereafter.

c. Develop and implement policies and procedures outlining:

i. QM/PI Program staff qualifications including education, certifications, experience, and training for each QM/PI Program position; and

ii. Mandatory QM/PI Program Staff or Management attendance at AHCCCS Contractor meetings unless attendance is specified as optional by AHCCCS.

d. Attend or participate in, and maintain associated documentation for, applicable community initiatives and collaborations as well as implement specific interventions to address overarching community concerns.

13. The Division shall oversee and maintain accountability for all functions and responsibilities as specified in AMPM Chapter 900, which are delegated to other entities.

14. The methodologies for oversight and accountability for all delegated functions shall be integrated into the overall QM/PI Program with the requirements, specified in AMPM Chapter 900, being met for all delegated functions. Accredited agencies shall be included in the Division's oversight process:

a. As a prerequisite to delegation, the Division shall provide a written analysis of its historical provision of QM/PI Program oversight function, which includes past goals and objectives. The level of effectiveness of the prior QM/PI Program oversight functions shall be documented.

Examples may include the number of claims, concerns, grievances, or network gaps;

b. The Division shall have policies and procedures requiring that the delegated entity report all allegations of QOC concerns and quality of service issues to the Division no later than 24 hours of awareness. QOC or service investigation and resolution processes shall not be delegated;

c. The Division shall Evaluate the entity's ability to perform the delegated activities prior to delegation. Evidence of such Evaluation includes the following:

   i. Review of appropriate internal areas, such as QM;

   ii. Review of policies and procedures and the implementation of them; and

   iii. Documented Evaluation and determination that the entity is able to effectively perform the delegated activities.

d. The Division shall establish a written contract prior to delegation, that specifies the delegated activities and reporting responsibilities of the entity to the Division;

e. The Division shall include in the agreement, the Division's right to terminate the contract or perform other remedies for inadequate performance;

f. The Division shall review annually and monitor performance of the entity and the quality of services provided on an ongoing basis.

g. The Division shall annually review a minimum of 30 randomly selected cases per line of business for each function that is delegated, keeping documentation on file for AHCCCS review.

h. The Division shall Monitor:

   i. Utilization;

   ii. Member and provider satisfaction;

   iii. QOC concerns; and

   iv. Complaints.

i. The Division shall review the performance and quality of services provided by entities that are accredited through the National Committee for Quality Assurance (NCQA) or another nationally recognized entity, reviewing a minimum of 10 randomly selected files per line of business for each function that is delegated.

j. The Division shall expand the sample to no less than 30 files in order to fully assess and identify issues and implement remediation efforts with the delegated service provider if any issues or concerns are noted within the files reviewed.

k. The Division shall submit Monitoring results to AHCCCS in accordance with ACOM Policy 438.

l. The Division shall keep the following documentation on file and available for AHCCCS review:

    i. Evaluation reports;

ii. Results of the Division's annual Monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions;

iii. Corrective Action Plans, or CAPs; and

iv. Appropriate follow up of the implementation of CAPs to ensure that quality and compliance with AHCCCS requirements for all delegated activities or functions are met.

D. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

1. The Division shall develop and implement mechanisms to Monitor and Evaluate its service delivery system and provider network that demonstrates compliance with all the requirements included within this Policy.
2. The Division's QM/PI Program QM staff shall directly oversee delegated entities conducting Monitoring activities.
3. The Division's QM/PI Program staff shall include the following Monitoring and Evaluation activities:

a. QM/PI Program scope of Monitoring and Evaluation be comprehensive and:

   i. Incorporate the activities used by the Division;

   ii. Demonstrate how these activities will improve the quality of services and the continuum of care in all services sites; and

   iii. Be clearly documented in policies and procedures.

b. If collaborative opportunities exist to coordinate organizational Monitoring, the lead Contractor coordinate and ensure that all requirements in the collaborative arrangement are met;

c. Monitor provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in AHCCCS Minimum Subcontract Provisions and Contract;

d. Information and data gleaned from QM/PI Program Monitoring and Evaluation that shows trends in QOC concerns are used in developing quality improvement

initiatives. Selection of specific Monitoring and Evaluation activities shall be appropriate to each specific service or site.

e. Development and implementation of methods for Monitoring PCP activities related to:

i. Referrals for behavioral health care,

ii. Coordination with the behavioral health system,

iii. Transfer of care, when clinically indicated, based on severity of behavioral health need, and

iv. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

a) Assurance of communication between prescribers, when controlled substances are used;

b) Provider-mandated usage of the CSPMP; and

c) Integration strategies and activities focused on improving individual health Outcomes;

enhancing care coordination, and increasing member satisfaction.

f. Development and implementation of methods for Monitoring behavioral health provider activities related to:

i. Referrals for physical health care;

ii. Coordination with the physical health system;

c. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

1) Assurance of communication between prescribers, when controlled substances are used;

2) Include provider-mandated usage of the CSPMP; and

3) Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing member satisfaction.

g. Reporting of all QOC concerns including:

i. Incidents of abuse, neglect, exploitation, suicide attempts, opioid-related concerns, alleged human rights violations, and unexpected deaths to the AHCCCS QM Team as soon as the Division is aware of the incident and no later than one business day, as specified in Contract. The Division is expected to investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service;

ii. Identified QOC concerns, reportable incidents, or service trends to the AHCCCS QM Team immediately upon identification.

1) Reporting shall include trend specifications such as providers, facilities, services, and allegation types;

2) Division QOC trend reports shall be incorporated into Monitoring and Evaluation

activities and presented to the QM/PI Committee; and

3) Policies and procedures shall be adopted to explain how the process is routinely completed.

h. Investigate all potential Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Condition (OPPC) as QOC concerns within the AHCCCS QM Portal as described in AMPM Policy 960.

i. Incorporation of the ADHS licensure and certification reports and other publicly reported data in their Monitoring process, as applicable.

j. A process to ensure notification is made to the Division's QM clinical staff when a delegated auditing entity identifies either a Health and Safety Concern, Immediate Jeopardy situation, or other serious incident, which impacts the health and safety of a member.

i. On-site reviews related to Health and Safety Concerns, Immediate Jeopardy situations, or other

serious incidents are to be conducted in accordance with the requirements as specified in AMPM Policy 960;

ii. In working to ensure health and safety of Members in placement settings or service sites that are found to have survey deficiencies or suspected issues that may impact the health and safety of AHCCCS Members, the Division shall:

1) Actively participant in both individual and coordinated efforts to improve the QOC in placement settings or service sites; and

2) Utilize clinical quality staff trained in QOC investigations to conduct on-site reviews if there is a health or safety concern identified either by the Division, AHCCCS, or other party.

k. The Division QM staff conduct the Monitoring of services and service sites, in accordance to Attachment A. While the Division may also consider incorporating regulatory

agency licensing reviews, such as annual inspection surveys, as part of the Monitoring of services and service sites, the regulatory agency reviews shall not be used as the sole basis for the entire Monitoring Evaluation by the Division. Refer to Attachment A for the list of AHCCCS services, service sites, and Monitoring frequency;

l. Implementation of policies and procedures for ALTCS Contractors specific to the annual Monitoring of attendant care, homemaker services, personal care services, respite services and habilitation services. When deficiencies or potential deficiencies are identified, they shall be addressed from a member and from a system perspective; and

m. Coordination of mandatory routine quality Monitoring and oversight activities for organizational providers, including home and community based service settings, when the provider included is in more than one Contractor network. A collaborative process shall be utilized in counties when

more than one Contractor is contracted with and utilizes the facility as specified in Contract. The Division, or the lead Contractor if Contractor collaborative Monitoring was completed, shall submit the Contractor Monitoring summary to AHCCCS QM Team as specified in Contract.

n. A standardized and agreed upon tool shall be used and contain:

i. General quality Monitoring of these services are the review and verification of:

1) The written documentation of timeliness;

2) The implementation of contingency plans;

3) Customer satisfaction information;

4) The effectiveness of service provisions;

5) Mandatory documents in the services or service site personnel file as follows:

a) Cardiopulmonary resuscitation;

b) First Aid;

c) Verification of skills or competencies to provide care;

d) Evidence that the agency contacted at least three references, one of which shall be a former employer. Results of the contacts shall be documented in the employee's personnel record; and

e) Evidence that the provider conducted the pre-hire and annually thereafter search of the APS Registry as required in AHCCCS Minimum Subcontract Provisions.

iii. Specific quality Monitoring requirements for ALTCS Contractors are as follows:

a) Direct Care Services, as specified in AMPM Policy 1240-A (Attendant care, Personal Care and Homemaker services), Monitoring as specified in Attachment B. Monitoring shall

include verification and documentation of all of the following:

1) Mandated written agreement between the member/Health Care Decision Maker, and designated representative and the Direct Care Worker (DCW), as specified in AMPM Policy 1240-A, which delineates the responsibilities of each;
2) Evaluation of the appropriateness of allowing the member's immediate relatives to provide direct care services;
3) Compliance with ensuring DCWs meet competencies to provide care including training, testing, verifying/sharing of DCW test records and continuing education requirements in accordance with Attachment B; and

4) Timeliness and content of supervisory visitations as specified in AMPM Policy 1240- A.

b) Sampling methodology for Monitoring of direct care services shall assure that all provider agencies and all employees have an equal opportunity to be sampled (provider agencies shall be included in the sample frame even if the number of employees does not meet a statistically significant level. All employees shall be included in the sample frame including those who are in the pool of workers but are not currently assigned to a member;

4. The Division shall have mechanisms to assess the quality and appropriateness of care provided to Members receiving LTSS services including between settings of care and, as compared to the member's service plan 42 CFR 438.330 (b)(5)(i);

5. The Division shall monitor that the LTSS services a member receives align with those that were documented in the member's LTSS treatment or service plan 42 CFR 438.330 (b)(5)(i); and
6. The Division may also consider incorporating the use of surveys to assess the experience of Members receiving LTSS services as a key component of the Division's LTSS assessment process.

SUPPLEMENTAL INFORMATION:

1. Changes in the QM/PI Program scope include any alterations made to the Division's QM/PI Program structure from one year to the next. This may also include line of business, population, and geographic service area changes.
2. Matters appropriate for peer review shall include, but are not limited to:

a. Cases where there is evidence of deficient quality,
b. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider, facility, or vendor,
c. Questionable clinical decisions, lack of care and/or substandard care,

d. Inappropriate interpersonal interactions, unethical behavior, physical, psychological, or verbal abuse, neglect, and exploitation of a member or members, family, staff, or other disruptive behavior demonstrated by a provider,

e. Criminal or felonious actions related to practice,

f. Issues that immediately impact the member and that are life threatening or dangerous, and

g. Issues that have the potential for adverse outcome.

3. Documentation for participation in applicable community initiatives and collaborations, as well as implement specific interventions to address overarching community concerns including, but not limited to:

a. Quality Management and Quality Improvement,

b. Maternal child health,

c. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Dental,

d. Chronic Disease management,

e. Long-Term Care

f. Behavioral health,

g. Justice Involvement,

h. Opioid and substance use,

i. Suicide,

j. Social determinants of health,

k. Veterans' resources and services, and

l. Specific community initiatives and collaborations, and as required by AHCCCS.

AHCCCS sponsored activities are not considered community initiatives or collaborations.

Signature of Chief Medical Officer: Anthony Dekker (Oct 4, 2023 16:50 PDT)
Anthony Dekker, D.O.

920 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE REQUIREMENTS

REVISION DATE: 8/16/2023, 4/20/2022, 10/1/2020
EFFECTIVE DATE: May 13, 2019
REFERENCES: CFR 42 CFR Part 438; 42 CFR 438.320; 42 CFR 438.310(c)(2); 42 CFR Part 457; 42 CFR 438.354; 42 CFR 438.358; AMPM 910; AMPM 920; AMPM 970; AMPM 980

PURPOSE

This policy specifies the Division's Quality Management and Performance Improvement (QM/PI) Program administrative requirements and explains how the Division monitors the performance of their Administrative Services Subcontractors (AdSS) for compliance with these requirements.

DEFINITIONS

1. "AHCCCS Division of Healthcare Management (DHCM), Quality Improvement (QI) Team" means AHCCCS staff who Evaluate the Division's Quality Management and Performance Improvement (QM/PI) Programs, monitors compliance with required Quality and Performance Improvement Standards Division Corrective Action Plans (CAPs) and Performance Improvement Projects

(PIPs) and provides technical assistance for QM/PI related matters.

2. "Corrective Action Plan (CAP)" means a written Work Plan that identifies the root cause(s) of a deficiency, includes goals and Objectives, actions, and tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and Objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Division and its providers, to enhance QM/PI activities and the Outcomes of the activities, or to resolve a deficiency.
3. "Evaluate" means the process used to examine and determine the level of Quality or the progress toward improvement of Quality and performance related to the Division's service delivery systems.
4. "External Quality Review (EQR)" means the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on Quality, timeliness, and access to

the health care services that the Division or AdSS furnish to Medicaid members [42 CFR 438.320].

5. "External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, performs EQR, and other EQR-related activities as specified in 42 CFR 438.358, or both [42 CFR 438.320].
6. "Measurable" means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive outcome.
7. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
8. "Objective" means a Measurable step, generally one of a series of progressive steps, to achieve a goal.
9. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].

10. "Performance Improvement Project (PIP)" means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of Care and service delivery.
11. "Performance Measure Performance Standards (PMPS)" means the minimal expected level of performance by the Division, previously referred to as the Minimum Performance Standard. Beginning Calendar Year End (CYE) 2021, official performance measure results shall be Evaluated based upon the National Committee on Quality Assurance (NCQA) HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services (CMS) Medicaid Median (for selected CMS Core Set-Only Measures) as identified by AHCCCS, as well as the Line of Business aggregate rates, as applicable.

12. "Quality" As it pertains to External Quality Review, means the degree to which Division increases the likelihood of desired Outcomes of its members through:

    a. Its structural and operational characteristics.

    b. The provision of services that are consistent with current professional, evidenced- based-knowledge.

    c. Interventions for performance improvement.

13. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

14. "Quality Management Unit (QMU), Quality Improvement (QI) Team" means Division staff who Evaluate AdSS Quality Management and Performance Improvement (QM/PI) Programs, monitor, and Evaluate compliance with required Quality and performance improvement standards through standardized Performance Measures (PM), Performance Improvement Projects

(PIPs), and Quality Improvement specific Corrective Action Plans (CAPs), as well as provide technical assistance for performance improvement related matters.

15. "Work Plan" means a document that addresses all the requirements of AMPM Chapter 900, and AHCCCS-suggested guidelines, as well as supports the Division's QM/PI goals and Objectives with Measurable goals (Specific, Measurable, Attainable, Relevant and Timely (SMART)), timelines, methodologies, and designated staff responsibilities. The Work Plan must include Measurable physical, behavioral, and oral health goals and Objectives.

16. "Work Plan Evaluation" means a detailed analysis of progress in meeting or exceeding the Quality Management and Performance Improvement (QM/PI) Program Objectives, strategies, and activities proposed to meet or exceed the performance standards and requirements as specified in contract and Division Medical Policy Chapter 900.

POLICY

A. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM PLAN

1. The Division shall develop a written QM/PI Program Plan that specifies the Objectives of its QM/PI Program and addresses the Division's approaches to meet or exceed the performance standards and requirements as specified in Contract and AMPM Chapter 900.
2. The Division shall submit its QM/PI Program Plan as specified in the AHCCCS contract.
3. The Division shall include the following in its QM/PI Program narrative:
    a. Objectives and plans for the upcoming calendar year to meet or exceed the requirements as specified in contract and in compliance with Division Medical Policy Chapter 900.
    b. Division activities to identify member needs and to coordinate care. Follow-up activities to ensure appropriate

and medically necessary treatment is received in a timely manner.

c. Division participation in community and Quality initiatives.

d. AHCCCS defined checklist items and guidance.

4. The Division shall include the following in its QM/PI Program Work Plan Evaluation:

a. Evidence or documentation supporting continued routine Monitoring to Evaluate the effectiveness of the actions and other follow up activities conducted throughout the previous calendar year.

b. A description of how any sustained goals or Objectives will be incorporated into the Division's business practice and develop new goals or Objectives once a goal or Objective has been sustained.

c. Performance measure related Plan-Do-Study-Act (PDSA) cycles that have been initiated, updated, or refined as part of the Division's ongoing Corrective Action Plan (CAP) Monitoring and Evaluation activities.

d. Goals not met will be addressed and considered for possible internal Performance Improvement Projects (PIPs).

5. The Division shall include the following in its QM/PI Work Plan:

a. Goals and Objectives that are realistic, Measurable, clinical, or non- clinical, and based upon established Performance Standards and requirements as specified in the current AHCCCS contract and Division Medical Policy Chapter 900 series when appropriate.

b. Other nationally recognized benchmarks as available to establish minimum performance standards or when performance standards have not been published by AHCCCS.

c. Strategies and activities to meet or accomplish the identified goals and Objectives.

d. Identify responsible staff positions accountable for meeting the established goals and Objectives.

e. PIPs designed to address opportunities for improvement identified from both external and internal sources.

6. The Division shall include the following in its Health Disparity Summary and Evaluation Report:

a. The process utilized to conduct disparity analyses including the analytical tools and the methodology for identifying disparities.

b. Disparity analysis findings associated projects and activities meant to ameliorate the disparity(s)and related Measurable goals or Objectives.

c. An evaluation of the disparity analysis findings, progress on targeted strategies and interventions, and progress on identified goals or Objectives.

d. Member-specific data including targeted inquiries and other related ad hoc reports.

e. A detailed evaluation of performance measure rates specific to subpopulations.

f. An analysis of the effectiveness of implemented strategies and interventions in meeting the Division's health equity goals and Objectives during the previous calendar year.

g. A detailed overview of the Division's identified health equity goals or Objectives for the upcoming calendar year to address noted disparities and promote health equity.

h. Targeted strategies or interventions planned for the upcoming calendar year to achieve its goals.

7. The Division shall include the following in its Engaging Members Through Technology (EMTT) – Executive Summary:

a. An evaluation of the previous calendar year's EMTT activities including:

i. The percent of members engaged through telehealth services and through web and mobile-based applications in comparison to total membership, and

ii. Member-specific metrics including targeted inquiries and other related ad hoc reports, for member-related

Outcomes in comparisons to identified goals and Objectives.

b. Criteria for identifying and targeting members who can benefit from telehealth services and from web and mobile-based applications, including but not limited to:
   i. The identification of populations who can benefit from telehealth services to increase access to care and services, and
   ii. The identification of populations who can benefit from web and mobile-based applications.
c. A description of telehealth services and web and mobile-based applications in development and currently being utilized to engage members.
d. Strategies used to engage the identified members in the use of telehealth services and web and mobile-based applications.
e. A description of desired goals and outcomes for telehealth services and for each web and mobile-based application

currently being utilized to engage members, including how the desired outcome will be measured and directly impact the overall Quality of and Access to care for the identified population(s).

f. The percentage of members anticipated to engage through telehealth services and through web and mobile-based applications during the upcoming calendar year based on the identified strategies and related goals or Objectives.

8. The Division shall submit a completed AMPM Policy 920 QM/PI Program Plan Checklist, including any Division or AdSS policies relevant to the QMPI Program that are new or have been substantially changed, along with its QM/PI Program Plan

B. BEST PRACTICES AND FOLLOW UP ON PREVIOUS YEAR'S EXTERNAL QUALITY REVIEW REPORT RECOMMENDATIONS

The Division shall submit recommendations as specified in contract and include:

1. An overview of self-reported best practices submitted as a stand-alone document, highlighting a minimum of three

initiatives aimed at improving care and services provided to members.

2. A summary of the Division's efforts to date in completing the most current and Previous Year's EQR Report Recommendations, as a stand-alone document.
3. Best Practices and Follow Up on Previous Year's EQR Report and Recommendations Checklist

C. PERFORMANCE MEASURE MONITORING REPORT

The Division shall develop and submit the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template and AHCCCS Performance Measure Monitoring Report & Work Plan Attachment. The report includes the following:

1. The Division's progress in meeting, sustaining, and improving its performance based on contractual requirements in accordance with the AHCCCS template and report format.
2. The internal rates for each performance measure.

3. Identified barriers in implementing planned interventions and opportunities for improvement intended to support meeting identified goals or Objectives.
4. Detailed analysis of results that includes an evaluation of the Division's performance compared to the following:
    a. Performance Measure Performance Standards in accordance with Division Medical Manual Policy 970.
    b. Self-identified goals and Objectives.
    c. Historical performance.

D. PERFORMANCE IMPROVEMENT PROJECT REPORT

The Division shall include in its Performance Improvement Project (PIP) Report annual updates for both AHCCCS-mandated and Division self-selected PIPs, in accordance with the Division Medical Manual Policy 980, including the use of AMPM Policy 980 Attachment C, Performance Improvement Project (PIP) Report DDD Specific.

E. CORRECTIVE ACTION PLAN

1. The Division shall develop and implement a Corrective Action Plan (CAP) for taking appropriate steps to improve care when issues are identified.
2. The Division shall submit All CAPs to AHCCCS for review and approval prior to implementation and include:
    a. The concern(s) that require corrective action.
    b. Identification of any deficiency and remedial steps to be taken to facilitate a return to compliance.
    c. Documentation of proposed time frames for CAP completion.
    d. Entities responsible for making the final determinations regarding QM/PI Program concerns.
    e. Actions to be taken including, but not limited to:
        i. Education, training, technical assistance,
        ii. Follow-up Monitoring and Evaluation of improvement as well as implementing new interventions, approaches, when necessary,
        iii. Changes in process, structure, and forms, and

iv. Informal counseling.

f. Documentation of performance Outcomes identified barriers, opportunities for improvement, and best practices.

g. Internal dissemination of CAP findings and results to appropriate committees, staff, and network providers.

h. Submit information to AHCCCS and other stakeholders as required.

i. For QOC specific CAPs, information is submitted in accordance with Division Medical Manual Policy 960.

3. The Division shall submit CAPs as required in AMPM Policy 920, Attachment B AHCCCS Quality Improvement Corrective Action Plan Proposal Checklist, and AHCCCS Quality Improvement Corrective Action Plan Update Checklist.

4. The Division shall maintain documentation regarding CAPs development, implementation, the performance outcomes, identified barriers, opportunities for improvement, and best

practices.

F. REPORTING REQUIREMENTS

1. The Division shall submit deliverables as specified in the contract and in accordance with AHCCCS/Division of Healthcare Management (DHCM) QI Team instructions and guidance.

2. If a time extension is necessary, the Division shall submit a formal request in writing no later than two business days before the deliverable due date explaining the basis for request and timeline extension to the AHCCCS/DHCM, Quality Management (QM), or Quality Improvement (QI) team manager, as appropriate to the deliverable.

3. The Division shall submit the QM/PI Program administrative deliverables as specified in contract and subject to AHCCCS approval. The Division shall submit any significant modifications to the QM/PI Program Plan throughout the year to the AHCCCS/DHCM, QM and QI team managers for review and approval prior to implementation.

4. The Division shall provide the QM/PI administrative deliverables and other select deliverable submissions to the AHCCCS EQRO with Division supplied information included within the Division's annual EQR Report posted to the AHCCCS website.

G. DOCUMENTATION REQUIREMENTS

1. The Division shall maintain records that document QM/PI Program activities. The required documentation includes:

   a. Studies and PIPs

   b. CAPs

   c. All required reports

   d. All processes, standards of work, and desktop procedures

   e. Meeting agendas, minutes, and accompanying documents

   f. Worksheets (including but not limited to excel spreadsheets, graphs, diagrams, flowcharts)

   g. Other information and data appropriate to support changes

made to the scope of the QM/PI Plan or Program

2. The Division shall make the records available to AHCCCS/DHCM, QM and QI teams upon request.

H. DIVISION OVERSIGHT OF ADMINISTRATIVE SERVICES SUBCONTRACTORS

1. The Division monitors each of the AdSS for compliance with the QM/PI Program administrative requirements throughout the contract year by reviewing required reports, status updates reported by the AdSS at Division meetings and during an annual operational review.

2. The Division may require the AdSS to submit a CAP or initiate a PIP when areas of non-compliance are noted.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 10:56 PDT)
Anthony Dekker, D.O.

940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATE: 9/6/2023
EFFECTIVE DATE: 5/18/2022
REFERENCES: A.R.S. §13-3620, 9 A.A.C. R9-10, 45, 9 A.A.C. 22-5, A.A.C. R9-22-503, 45 CFR 160, 162, and 164 ,42 CFR 431, 431.300 et seq., 438.2, 438.100(a)(1), 438.100(b)(2)(vi), 457.10, Part 2, 2.1-2.67, 42 U.S.C. §290 dd-2, Division Medical Manual Policy 320-O, 320-R, 410, AdSS Medical Manual Policy 940

PURPOSE

This policy applies to the Division of Developmental (Division) Service Providers. This policy establishes requirements for protection of Member information, documentation requirements for Member physical and behavioral health records, and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems.

DEFINITIONS

1. "Adult Recovery Teams" or "ARTs" means A group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and

service delivery made up of the following people:

a. The Member;

b. The Member's Health Care Decision Maker (HCDM), if one is in place);

c. Any assigned advocates;

d. A qualified behavioral health representative; and

e. Other individuals identified by the Member or HCDM such as. he Member's family, physical health, behavioral health or social service providers, other agencies serving the Member, and professionals representing various areas of expertise related to the Member's needs.

2. "Arizona Association of Health Plans" or "AzAHP" means an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the contractors with regard

to the behavioral health chart audit process.

3. "Child and Family Teams" or "CFTs" means a group of individuals made up of the following people:

   a. The child and their family, orHCDM;

   b. A behavioral health representative, and

   c. Any individuals important in the child's life that are identified and invited to participate by the child and family.

4. "Designated Record Set" or "DRS" means a group of records maintained by the Provider that contain following:

   a. Medical and billing records maintained by the Provider;

   b. Case and medical management records; or

   c. Any other records used by the Provider to make medical decisions about the Member.

5. "Health Information Exchange" or "HIE" means the secure sharing of patient health information among authorized Providers.

   a. HIE is a process or action that can be facilitated by an HIO.

   b. HIE can also include the secure sharing of patient health information directly between providers .

6. “Health Information Organization” or “HIO” means an entity that facilitates the secure exchange of electronic patient health information between participating Providers .

7. “Medical Records” means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers, in both hard copy and electronic form. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 122291.

8. “Member” means the same as “Client” prescribed in A.R.S. § 36.551.

9. “Multi-Specialty Interdisciplinary Clinic” or “ (MSIC”) - An means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.

10. “Provider” means an individual or organization that contracts with the Division for the provision of covered services, or ordering or referring

for those services, to an eligible Division Member, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require Providers to maintain comprehensive documentation related to care and services provided to Members.
2. The Division shall ensure, via regular monitoring activities, that documentation completed and is maintained by the Providers meets the requirements specified in this policy.

B. MEDICAL RECORDS REQUIREMENTS

1. The Division shall required Providers to maintain the following in their Medical Records:
    a. Up to date, well organized and comprehensive documentation, with sufficient detail to promote effective Member care and ease of quality review.
    b. Documentation of the following identifying demographic:

i. The Member's name,

ii. Address,

iii. Telephone number,

iv. AHCCCS identification number,

v. Gender,

vi. Age,

vii. Date of birth,

x. Marital status,

xi. Next of kin,

xii. Parent, guardian, or healthcare decision maker , if applicable.

c. The following Member identification information on the first page of the medical record:

i. Member name,

ii. Member AHCCCS ID,

iii. Member date of birth.

d. Member name and either AHCCCS ID or member date of birth on the subsequent pages of the Medical Record.

e. The following past medical history:

i. Disabilities,

ii. Any previous illness or injuries,

iii. Smoking,

iv. Alcohol/substance use,

v. Allergies,

vi. Adverse reactions to medications,

vii. Hospitalizations, to include discharge summaries,

viii. Surgeries,

ix. Emergent/urgent care received,

x. Immunization records: required for children, recommended for adult Members if available.

2. The Division shall require Providers to do the following regarding Medical Records:

a. Hard copy Medical Records be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry.

b. Electronic format Medical Records contain the name of the Provider who made the entry and the date for each entry.

c. If revisions to information are made, a system is in place to track when, and by whom the revisions are made.

d. That a back-up system is maintained that tracks initial and revised information.

e. That if a Medical Record is physically altered:

   i. The stricken information be identified as a correction and initialed by the rendering Provider altering the record, along with the date when the change was made;

   ii. That correction fluid or tape is not used;

   iii. If Medical Records are kept in an electronic file, the Provider must establish a method for indicating the author; date; and time of added and revised information.

   iv. Ensure that information is not inadvertently altered.

f. That Providers in multi-Provider offices must have the treating provider sign their treatment notes after each appointment and procedure and occurs as close to the actual entry of treatment notes as possible, based on

either professional standards of care/or requirements specified within 9 A.A.C. R9-10.

g. That evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances is documented in the Medical Record.

3. The Division shall require the Provider to document the following coordination of care activities when they occur:

a. Referrals to other Providers;

b. Transmission of the diagnostic, treatment, and disposition information related to a specific Member to the requesting Provider, as appropriate to promote continuity of care and quality management of the Member's health care;

c. Reports from referrals, consultations, and specialists for behavioral and physical health, as applicable;

d. Emergency and urgent care reports;

e. Hospital discharge summaries;

f. Transfer of care to other Providers;

g. Any notification when a Member's health status changes or new medications are prescribed;

h. Legal documentation that includes:

i. Documentation related to requests for release of information and subsequent releases,

ii. Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker, and

iii. Copies of any Advance Directives or Mental Health Care Power of Attorney as follows:

a) Documentation that the adult Member was provided the information on Advance Directives and whether an Advance Directive was executed, as specified in AdSS Medical Policy 640;

b) Documentation of general and informed consent to treatment, as specified in AdSS Medical Policy 320-Q; and

c) Authorization to disclose information.

4. The Division shall refer to AMPM Policy 710 for Medical Record information regarding Members who receive Medicaid direct services through their school system.

C. PRIMARY CARE PROVIDERS PHYSICAL HEALTH MEDICAL RECORD REQUIREMENTS

1. The Division shall require any Provider delivering primary care services to a Member and acting as their Primary Care Provider (PCP) to maintains a comprehensive record that incorporates the following components:

   a. Initial history and comprehensive physical examination findings for the Member that includes family medical history, social history and preventive laboratory screenings.

   b. For Members under age 21, the initial history of prenatal care and birth history of the Member's mother while pregnant with the Member, if known;

   c. Documentation of any requests for forwarding of behavioral health and other Medical Record information;

   d. Behavioral health history and information when received

from a TRBHA or other the behavioral health Provider involved with the Member's behavioral health care;

e. If the Provider has not yet seen the assigned Member, Medical information detailed in this subsection may be kept in an appropriately labeled file until associated with the Member's Medical Record as soon as the Medical Record is established;

f. Documentation, initialed by the Provider, to signify review of the following diagnostic information:

i. Laboratory tests and screenings,

ii. Radiology reports,

iii. Physical examination notes,

iv. Medications,

v. Last Provider visit,

vi. Recent hospitalizations, and

vii. Other pertinent data to the Member's health conditions;

g. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools;

h. Current and complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Tracking forms or an equivalent including, at minimum all data elements on the EPSDT Tracking Form for:

i. All Members age 0 through 20 years;

ii. Developmental screening tools for children ages nine, 18, and 24 months;

iii. Dental history if available, and current dental needs and services;

iv. Current problem list;

v. Current medications list;

vi. Documentation to reflect review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances; and

vii. Evidence that obstetric Providers complete a standardized, evidence-based risk assessment tool for obstetric Members as detailed in AdSS Medical Policy 410.

D. BEHAVIORAL HEALTH MEDICAL RECORD REQUIREMENTS

The Division shall require the following elements to be included in all behavioral health Medical Records:

a. Initial behavioral health evaluation containing the following:

i. Documentation of the Member's choice for receipt of the Member Handbook, either hard copy or electronic format;

ii. Receipt of Notice of Privacy Practice;

iii. Contact information for the Member's PCP;

iv. Financial documentation for Non-Title XIX/XXI Members receiving behavioral health services, as outlined in AMPM Policy 650 occuring at the following:

a) At the initial evaluation appointment,

b) When the Member has had a significant change in their income, and

c) At least annually.

b. Behavioral health assessment documentation consisting of:

i. Documentation of all information collected in the

behavioral health assessment and any applicable addenda and required demographic information;

ii. Diagnostic information including psychiatric, psychological, and physical health evaluations;

iii. Evaluation of the need for reporting as required under A.R.S. §13- 3620;

iv. Copies of documentation related to the need for special assistance, if applicable, as detailed in. AdSS Medical Policy 320-R; and

v. An English version of the behavioral health assessment, Service Plan, and Treatment Plan, when applicable, if the documents are completed in any language other than English.

c. Service Plan documentation that contains:

i. The Member's Service Plan or Treatment Plan, as applicable;

ii. CFT documentation, based on Member's age (0 to

18 or up to 21 should Member choose to continue with Child & Family team after turning 18);

iii. ARTs documentation for adults 18 and older ; and

iv. Progress Reports, Service Plans, or Treatment Plans from all other Providers, as applicable.

d. Progress note documentation that includes:

i. Documentation of the type of services provided;

ii. The diagnosis, containing an indicator that identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis;

iii. The progress note diagnosis code, if applicable;

iv. The date the service was delivered;

v. The date and time the progress note was signed;

vi. The signature of the staff that provided the service, including the staff Member's credentials;

v. Duration of the service (time increments);

vi. A description of what occurred during the provision of the service related to the Member's

Service Plan;

vii. Documentation of the need for the involvement of multiple Providers, including the name and roles of each Provider involved in the delivery of services, in the event that more than one Provider simultaneously provides the same service to a Member; and

viii. The Member's response to service.

e. The Notice of Extension (NOE) and any other documentation used for the processing of any applicable appeal that was sent to the Member and their legal guardian or authorized representative.

E. REQUIREMENTS FOR POLICIES AND PROCEDURES FOR ENSURING MEDICAL RECORD CONTENT

1. The Division shall implement and maintain policies and procedures to ensure that Providers have information required to monitor effective and continuous physical and behavioral health care for Members through accurate Medical Record documentation regardless of whether

records are hard copy or electronic via:

a. Onsite or electronic quality review;

b. Initial and on-going monitoring of Medical Records;

c. Review of health status, changes in health status, health care needs, and services provided;

d. Review of coordination of care activities;

e. Maintenance of a legible Medical Record for each Member who has been seen for physical and behavioral health appointments and procedures;

f. The Medical record shall also contain clinical records from other Providers who also provide care or/ services to the Member; and

g. Medical Record requirements for hard copy and electronic Medical Records.

2. The Division shall have policies and procedures in place that meet federal and state requirements including those related to security and privacy in accordance with 45 CFR 160, 162, and 164, 45 CFR 43142 CFR 431.300 et seq., and Medicaid Information Technology Architecture (MITA) for the use of

electronic Medical Records and for HIE via the state's HIO and digital (electronic) signatures that contain the following elements:

a. Signer authentication;

b. Message authentication;

c. Affirmative act (i.e. an approval function such as a signature which establishes the sense of having legally consummated a transaction);

d. Efficiency; and

e. Medical Record review.

3. The AdSS shall implement policies and procedures that:

a. Support Members' rights to request and receive a copy of their Medical Record at no cost and to request that the Medical Record be amended or corrected;

b. Ensure information from or copies of Medical Records are released only to the Member or their Health Care Decision Maker.

c. Ensure that unauthorized individuals cannot gain access to, or alter Member Medical Records;. and

d. Ensure Medical Records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of Member medical information.

4. The Division shall have written policies and procedures addressing appropriate and confidential exchange of Member information among Providers.

5. The Division shall conduct reviews of Provider's policies and procedures to verify that they contain the following requirements:

   a. A Provider making a referral are to transmits necessary information to the Provider receiving the referral,

   b. A Provider furnishing a referral service reports appropriate information to the referring Provider,

   c. Providers request information from other treating Providers as necessary to provide appropriate and timely care, and

   d. Information about services provided to a Member by a non-network provider is transmitted to the Member's Provider:

e. Medical Records are transferred to the new Provider within 10 business days from receipt of the request for transfer of Medical Records to ensure continuity of care when a Member chooses a new Provider; and

f. Member information is shared when a Member enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

F. METHODOLOGY FOR CONDUCTING MEDICAL RECORD REVIEW PROCESS

1. The Division shall require that the Medical Record audit process includes the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit.
2. The Division may, if they choose, utilize the AAzAHP to conduct Medical Record review and other Provider documentation review processes.
3. The Division shall utilize the following methodology when conducting a Medical Record review of Providers:
   a. Medical Record reviews using a standardized tool that has been reviewed by AHCCCS.

b. Review the following physical health records:

   i. EPSDT,

   ii. Family planning, and

   iii. Maternity components not otherwise monitored for Provider compliance by the Division.

c. Review the following elements of behavioral health Medical Records:

   i. Assessments; and

   ii. Service and treatment planning.

   iii. Ensure individual elements delineate which requirements pertain to:

      a) The unique needs of individual lines of business,

      b) The following special populations:

         1) General Mental Health/Substance Use (GMH/SU),

         2) Serious Mental Illness (SMI),

         3) Special Health Care Needs (SHCN),

4) Comprehensive Health Plan (CHP), or

5) Individuals receiving services under

d. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. At a minimum of every three years for physical health charts; and

ii. Yearly for behavioral health charts.

e. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. Conduct medical records reviews at a minimum of every three years for physical health charts (AMRR); and

ii. Yearly for behavioral health charts.

f. Use of AdSSThe Division staff with the appropriate licensure and experience necessary for completion of either clinical charts for behavioral health services or physical health services to conduct the Medical Record reviews.

i. The Division shall utilize licensed behavioral health professionals (BHPs) or behavioral health technicians (BHTs) with a minimum of three years' experience as a BHT and under the supervision of a BHP for behavioral health clinical chart audits; and

ii. The Division shall utilize a registered nurse (RN) or a licensed practical nurse (LPN) with current licensure under the Arizona State Board of Nursing for AMRR audits.

4. The Division shall make available the results of the Medical Record review to all contractors who utilize a consultant such as AzAHP, or in instances when multiple contractors share the same Provider for this process.

5. The Division shall share the deficiencies identified during a Medical Record review with all health plans contracted with the Provider.

6. If quality of care issues are identified during the Medical Record review process, the Division shall notify all

contractors which contract with the identified Provider within 24 hours of identification of the quality of care issue with specifics concerning the quality of care issue.

7. If the Division requests approval from AHCCCS to discontinue conducting the Medical Record reviews, the Division shall do the following prior to making the request:
   a. Conduct a comprehensive review the use of the Medical Record review process and how the process is used to document compliance with the Division and AHCCCS requirements;
   b. Document what processes will be used in place of the Medical Record review process to ensure compliance with the Division and AHCCCS requirements; and
   c. Submit the process the AdSS will utilize to ensure Provider compliance with the Division and AHCCCS Medical Record requirements to the AHCCCS/Quality Management/, Clinical Quality Management Administrator prior to discontinuing the Medical Record review process.
8. The Division shall include all PCPs that serve Members less

than 21 years of age and obstetricians/gynecologists in the AMRR process.

9. The Division shall review process shall consist of reviewing eight charts per practitioner and include the requirements specified in contract as a part of the AMRR.

10. The Division shall include in the behavioral health Medical Record review process:

    a. Behavioral Health Outpatient Clinics, and

    b. Integrated Health Homes and Federally Qualified Healthcare Centers (FQHCs) if they provide both behavioral health and physical health care.

11. The Division shall follow the medical review process for behavioral health records as specified in contract.

12. For changes in methodology or sampling, the Division shall submit to AHCCCS in advance for approval as specified in the contract.

G. MULTI-SPECIALTY INTEGRATED CLINIC

1. The Division shall implement written policies and procedures to require that MSICs have an integrated

electronic Medical Record for each Member that is served through the MSIC.

2. The Division shall require the MSIC's integrated electronic Medical Record:

   a. Be available, electronically through the HIE, for the multi-specialty treatment team and community Providers;

   b. Contains all information necessary to facilitate the coordination and quality of care delivered by multiple Providers in multiple locations at varying times; and

   c. For care coordination purposes, is shared with other care Providers, such as the multi-specialty interdisciplinary team.

H. COMMUNITY SERVICE AGENCY, THERAPEUTIC FOSTER CARE PROVIDERS, AND HABILITATION PROVIDER REQUIREMENTS

1. For Community Service Agencies (CSAs), Therapeutic Foster Care (TFC) Providers, and Habilitation Providers, the Divisions shall require that the Medical Records conform to the following standards:

a. Each record entry be:

1. Dated and signed with credentials noted;

2. Legible text, written in blue or black ink, or typewritten; and

3. Factual and correct.

2. If Medical Records are kept in more than one location, the Division shall require the agency Provider to:

a. Maintain documentation specifying the location of the Medical Records;

b. Maintain a Medical Record of the services delivered to each Member; and

c. Meet the following requirement for each Member's Medical Record:

i. The service provided and the time increment;

ii. Signature and the date the service was provided;

iii. The name, title, and credentials of the professional providing the service;

iv. The Member's Date of Birth and AHCCCS

identification number;

v. Documentation that services are reflected in the Member's Service Plan or Treatment Plan, as applicable;

vi. Maintain a copy of the Member's Service Plan or Treatment Plan, as applicable, in the Member's Medical Record; and

vii. Maintain a monthly summary of service documentation progress toward treatment goals.

d. The Division shall require Providers to transmit a summary of the monthly summary of service to the Member's clinical team for inclusion in the comprehensive Medical Record.

I. DESIGNATED RECORD SET

1. The Division shall treat the DRS as the property of the Provider who generates the DRS.
2. The Division shall require that Providers allow Members to:
   a. Review, request, and annually receive a copy, free of charge, of those portions of the DRS generated

by the Provider;

b. Request that specific Provider information is amended or corrected; and

c. Not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under Health Insurance Portability and Accountability Act (HIPAA).

3. The Division shall provide sufficient copies of records necessary for administrative purposes to AHCCCS free of charge for purposes relating to treatment, payment, or health care operations.

4. The Division shall not require the PCP to obtain written approval from the Member when:

a. Transmitting Medical Records to a Provider when services are rendered to the Member through referral to a Division subcontracted Provider,

b. Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services, or

c. Sharing Medical Records with the Member's AdSS.

5. The Division shall require AHCCCS-registered Providers to forward Medical Records or copies of Medical Record information related to a Member to the Member's PCP within 10 business days from receipt of a request from the Member or the Member's PCP.
6. The Division shall provide access to AHCCCS to all Medical Records, whether electronic or hard copy, within 20 business days of receipt of a request.
7. The Division shall release information related to fraud, waste, or abuse against the AHCCCS program to authorized officials in compliance with Federal and State statutes and rules.
8. The Division shall demonstrate evidence of professional and community standards and accepted and recognized evidence-based practice guidelines as specified inDivision Medical Manual Chapter 500.
9. The Division shall require Providers to have an implemented process to assess and improve the content, legibility, organization, and completeness of Medical Records when

concerns are identified with the Providers Medical Records.

10. The Division shall require documentation in the Medical Record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

J. LEGAL REQUIREMENTS FOR RECORD MAINTENANCE

1. Consistent with 9 A.A.C. 22, Article 5, the Division, and Providers, and non-contracted entities providing services to Members shall safeguard the privacy of Medical Records and information about Members who request or receive services from AHCCCS or its contractors.
2. The Division shall require that tThe content of any Medical Record be disclosed in accordance with the prior written consent of the Member with respect to whom such record is maintained as allowed under regulations prescribed pursuant to 42 U.S.C. §290 dd-2 (confidentiality of records), 42 CFR Part 2, 2.1 – 2.67.
3. The Division shall release original and copies of Medical Records

shall only in accordance with Federal or State laws, and AHCCCS and Division policy and contracts.

4. The Division shall comply with HIPAA requirements and 42 CFR 431.300 et seq.
5. The Division shall align the Medical Records retention processes with AHCCCS and Division contract and TRBHA Intergovernmental Agreement (IGA) requirements.
6. The Division shall require that maintenance and access to Medical Records survive the termination of a Provider's contract regardless of the cause of termination.
7. The Division and Providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.
8. The Division shall encourage non-contracted entities that provide services to Members to cooperate and participate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.

K. UNITED STATES CORE DATA FOR INTEROPERABILITY

The Division shall incorporate United States Core Data for

Interoperability (USCDI) Data Elements as part of the DRS to facilitate the electronic exchange of an individual's Medical Record data as requested by the individual.

Signature of Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:22 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

The requirements listed below are additional requirements under USCDI. The Division and AHCCCS strongly recommend these enhanced data elements be added to the existing Physical and Behavioral Health Medical Record requirements specified in this policy. Per the ONCs, disclosure of these additional data elements is subject to the confidentiality requirements of applicable state laws.

1. Medical Record requirements are applicable to both hard copy and electronic Medical Records. Medical Records may be documented on hard copy or in an electronic format. The AdSS' Providers shall include the following in their records:
2. Documentation of identifying demographics, including:

a. Any previous names by which the Member is known,

b. Previous address,

c. Telephone number with cell or home designation, and both if applicable,

d. Email address,

e. Birth sex,

f. Race,

g. Ethnicity, and

h. Preferred language.

3. For records relating to provision of behavioral health services, documentation including, but not limited to:

a. Behavioral health history,

b. Applicable assessments,

c. Service plans and/or treatment plans,

d. Crisis and/or safety plan,

e. Medication information if related to behavioral health diagnosis,

f. Medication informed consents, if applicable

g. Progress notes, and

h. General and/or informed consent.

4. Documentation, initialed by the Provider, to signify review of diagnostic information including vital signs data at each visit, to include:
    a. Body temperature,
    b. Diastolic and Systolic blood pressure,
    c. Body height and weight,
    d. BMI Percentile (two -20 years),
    e. Weight-for-length percentile (birth-36 months),
    f. Head occipital-frontal circumference percentile (birth-36 months),
    g. Heart rate and respiratory rate,
    h. Pulse oximetry,
    i. Inhaled oxygen concentration, and
    j. Unique device identifier(s) for implantable device(s), as applicable.
5. For Inpatient Settings – Clinical Note Requirements:
    a. Consultation notes,
    b. Discharge and summary notes,
    c. History and physical,
    d. Imaging narrative,

e. Laboratory report narrative,

f. Pathology report narrative,

g. Procedure notes, and

h. Progress notes.

950 CREDENTIALING AND RECREDENTIALING PROCESSES

REVISION DATE: 9/6/23, 5/18/22, 5/23/18, 5/05/17

EFFECTIVE DATE: May 3, 2016

REFERENCES: 42 CFR 8.11, 42 CFR 438, 42 CFR 455, Subpart B, 42 CFR 457.1208, 42 CFR 457.1233(a); A.A.C. 21, Article 1 through Article 4, A.A.C. R9-10-18, R9-10-115, R9-10-1803; A.R.S. §36- 2918.01, §36-2905.04, §36-2932, AMPM Policy 950

PURPOSE

This policy establishes the requirements for initial Credentialing, temporary/provisional Credentialing, and recredentialing of individual and Organizational Providers contracted with the Division of Developmental Disabilities (Division) and oversight of the Credentialing responsibilities delegated to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. “Adverse Action” means any type of restriction placed on a Provider’s practice, including contract termination, suspension, limitations, continuing education requirements, monitoring, supervision.
2. “Completed Application” means when all accurate information and documentation is available to make an informed decision about the

Provider.

3. "Credentialing" means a process in which written evidence of qualifications are obtained in order for practitioners to participate under contract with a specific health plan.
4. Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
6. "Primary Source Verification" means the process by which an individual Provider's reported credentials and qualifications are confirmed with the original source or an approved agent of that source.
7. "Provider" means any individual or entity that contracts with the Division for the provision of covered services, or ordering or referring for those services to Division Members, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The Division shall verify Providers are properly trained, certified or licensed, and have the required experience to provide care

and services to Division Members.

2. The Division's Credentialing Unit shall credential and recredential individual and Organizational Providers contracted with the Division.
3. The Division shall credential Organizational Providers who have an agreement with the Division to provide residential placements, day and employment programs, Adult and Child Developmental Homes, home community-based services, and occupational, physical, and speech language therapies.
4. The Division shall delegate the Credentialing responsibilities of individual health care Providers to the Division's AdSS, except for occupational, physical, and speech language therapists that contract directly with the Division.
5. The Division shall retain the right to approve, suspend, or terminate any Provider credentialed by the AdSS.
6. The Division shall ensure the Credentialing and Recredentialing processes:
    a. Do not base Credentialing decisions on an applicant's race, gender, age, sexual orientation, or patient type in which the Provider specializes.

b. Do not discriminate against Providers who serve high-risk populations or who specialize in the treatment of costly conditions.

c. Comply with federal requirements that prohibit employment or contracts with Providers excluded from participation under either Medicare or Medicaid, or that employ individuals or entities that are excluded from participation.

7. The Division shall ensure Providers have capabilities to ensure physical access, reasonable accommodation, and accessible equipment for Members with physical and mental disabilities. [42 CFR.457.1230 (a), 42 CFR 438.206(c)(2) (3)].

8. The Division shall ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

B. CREDENTIALING COMMITTEE

1. The Division's Credentialing Committee shall be responsible for

the Credentialing process under the purview of the Quality Management Unit (QMU).

2. The Chief Medical Officer (CMO) or Quality Management Medical Director, in the absence of the CMO, shall oversee the Credentialing process and serve as chair of the committee.
3. The Credentialing Committee shall review and approve or deny Credentialing applications presented at each Committee meeting.
4. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider, including the final determination of the Committee for all initial, temporary/provisional, and recredentialed Providers reviewed by the Committee.
5. The Division's Credentialing Unit shall verify the information for presentation to the Credentialing Committee within 60 calendar days of receipt of all required documentation.
6. The Division shall notify the Providers of the Credentialing decision within 10 calendar days of the Credentialing Committee’s decision.

7. The CMO or Quality Management Medical Director's signature shall serve as evidence of the Credentialing Committee's final decision.
8. The Division shall enter the credentialed Providers in the claims payment system within 30 calendar days of Credentialing Committee approval with an effective date no later than the date the Provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

C. TEMPORARY/PROVISIONAL CREDENTIALING

1. The Division shall grant temporary/provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care or services prior to the completion of the entire Credentialing process.
2. The Division may credential Providers using the temporary/ provisional Credentialing process, even if the Provider does not specifically request their application be processed as temporary/ provisional, if they meet any of the following criteria:

    a. Providers needed in medically underserved areas.

    b. Covering or substitute Providers rendering services to the

Division's Members during a contracted Provider's absence from the practice.

c. As directed by Arizona Health Care Cost Containment System (AHCCCS) during federal or state declared emergencies where delivery systems are, or have the potential to be, disrupted.

3. The CMO or Medical Director shall review the initial verified and validated Credentialing documents and make a determination within 14 calendar days from the date of request or identified need regarding temporary/provisional Credentialing.

4. If approved by the CMO or Medical Director, the Division's Credentialing Unit shall notify the Provider and the Division's Contract Management Unit of the service(s) approved for temporary/provisional Credentialing.

5. The Division's Contract Management Unit shall enter a service start date in order for the Provider to be uploaded into the claims system.

6. The Division's Credentialing Unit shall inform the Provider, in the Credentialing notification letter, that the entire initial

Credentialing process will be completed within 60 calendar days of issuance of the temporary/provisional Credentialing.

7. The Credentialing Committee shall consider the Provider's Credentialing information at the next Committee meeting for consideration of initial Credentialing.

D. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The Division shall credential the following individual Provider when contracted directly with the Division:
   a. Occupational Therapist,
   b. Physical Therapist, and
   c. Speech and Language Pathologist.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider that contains:
   a. A Completed Application signed and dated by the Provider

that attests to the following elements:

i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

ii. Lack of present illegal drug use;

iii. History of loss of license or felony conviction;

iv. History of loss or limitation of privileges or disciplinary action;

v. Current malpractice insurance coverage;

vi. Attestation by the Provider of the correctness and completeness of the application; a copy of the signed attestation shall be included in the Provider's Credentialing file; and

vii. Minimum five-year history or total history if less than five years.

b. Drug Enforcement Administration and Chemical Database Service certification if a prescriber.

c. Verification from primary sources of:

i. Licensure or certification.

ii. Board certification, if applicable, or highest level of

credentials attained.

E. RECREDENTIALING INDIVIDUAL PROVIDERS

1. The Credentialing Unit shall recredential Individual Providers at least every three years and:

   a. Update the information obtained during the initial Credentialing process;

   b. Verify continuing education requirements are met, if applicable;

   c. Monitor Provider specific information related to:

      i. Member concerns and grievances;

      ii. Utilization management information;

      iii. Performance improvement and monitoring, if applicable;

      iv. Results of medical record review audits, if applicable;

      v. Quality of care issues including trend data;

      vi. Pay for performance and value-driven healthcare data and outcomes if applicable; and

      vii. Evidence that the Provider's policies and procedures meet Division requirements.

2. The Credentialing Committee shall make a Recredentialing decision within three years from the previous Credentialing approval date based on Primary Source Verification current within 180 days.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contract execution of an Organizational Provider, the Division shall ensure the Organizational Provider has established policies and procedures that meet AHCCCS requirements, including policies and procedures for Credentialing and recredentialing when those functions are delegated to the Organizational Provider and meet the requirements specified in this section.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Organizational Provider that contains:

a. The Completed Application and signed attestation by the Provider of the correctness and completeness of the application;

b. An executed qualified vendor agreement;

c. AHCCCS Registration;

d. The completed District-level readiness review;

e. Confirmation the Provider has met all the state and federal licensing and regulatory requirements;

f. A completed onsite quality assessment;

g. Central Registry check;

h. Criminal background check;

i. Electronic Visit Verification attestation, if applicable;

j. Office of the Inspector General List of Excluded Individuals or Entities check;

k. Social Security Administration Death Master File check;

l. Completed State of Arizona Substitute W-9;

m. System for Award Management registration;

n. Department of Economic Security, Office of Licensing, Certification, Regulation, and Home and Community Based Services Certificate;

o. Proof of insurance that includes general liability, professional liability, worker's compensation, and sexual abuse and molestation coverage;

p. Business license;

q. A maintenance schedule for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children; and

r. Any other pertinent information used to determine that the Provider meets the Division's Credentialing and recredentialing standards.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The Credentialing Committee shall recredential Organizational Providers at least every three years.

2. The Credentialing Committee shall review a verified completed Credentialing/Recredentialing file that includes updated and verified status of the initial information.

3. The Division's Credentialing Unit shall verify the completeness of the file for each recredentialed Organizational Provider using the following components:

   a. Confirmation that the Organizational Provider remains in good standing with state and federal bodies by validating that the Organizational Provider:

      i. Is licensed to operate in the state and is in compliance with any other state or federal requirements as applicable; and

      ii. Is reviewed and approved by an appropriate accrediting body.

      iii. If an Organizational Provider is not accredited or surveyed and licensed by the state, an onsite review is conducted.

   b. Review of the following:

i. Current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings;

ii. Hospital Compare Az Care Check, if applicable;

iii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications;

iv. Supervision of staff and required documentation of direct supervision or clinical oversight as required in A.A.C R9-10-115, including, if applicable, review of a valid sample of clinical Member charts;

v. Most recent audit results of the Organizational Provider;

vi. Confirmation that the service delivery address is correct; and

vii. Verification that staff meet the Credentialing requirements.

c. Evaluation of Organizational Provider specific information related to:

i. Member concerns and grievances;

ii. Utilization management information;

iii. Performance improvement and monitoring;

iv. Quality of care issues;

v. Onsite assessment;

vi. Review of any Adverse Actions;

vii. Value-based purchasing results and level of Member satisfaction for recredentialing;

4. The Credentialing Committee shall review and approve all Credentialing decisions with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

5. The Division shall reviewand monitor other types of Organizational Providers in accordance with the AHCCCS contract.

G. NOTIFICATION REQUIREMENTS

1. The Division's Contract Actions Unit shall report any issues that result in a Provider's suspension or termination from the network

to the AHCCCS/DHMC/QM within one business day of determination to take the Adverse Action.

2. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the Division shall notify the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.
3. The Division's Credentialing Unit shall report allegations of Provider misconduct or misuse of prescribing practices to licensing and other regulatory entities as appropriate.
4. The Division's Credentialing Unit shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHMC/QM within one business day of determination to take Adverse Action, and include the reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.
5. The Division shall have an appeal process for Providers when restrictions are placed on the Provider's contract based on issues of quality of care or service and process to inform the Provider of the Quality Management dispute process through the QMU.
6. The Division shall report to AHCCCS/DHMC/QM in writing, any

final Adverse Action taken for any quality-related reason against a Provider, supplier, vendor, or practitioner within one business day of the final Adverse Action taken.

7. The Division shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.

8. The Division shall consider the following to be a final Adverse Action:

   a. Civil judgments in federal or state court related to the delivery of a health care item or service.

   b. Federal or state criminal convictions related to the delivery of a health care item or service.

   c. Actions by federal or state agencies responsible for the licensing and certification of health care Providers, suppliers, and licensed health care practitioners, including:

      i. Formal or official actions such as restriction, revocation, suspension of license and length of suspension, reprimand, censure or probation.

ii. Any other loss of license or the right to apply for or renew a license of the Provider, supplier or practitioner, whether by operation of law, voluntary surrender, non-renewability or otherwise; or

iii. Any other negative action or finding by such federal or state agency that is publicly available information.

iv. Exclusion from participation in federal or state health care programs as defined in 42 CFR 455 Subpart B; and

v. Any other adjudicated actions or decisions that the Secretary of the U.S. Department of Health and Human Services shall establish by regulation.

vi. Any adverse Credentialing decision made on the basis of quality-related issues or concerns.

vii. Any Adverse Action from a quality or peer review process that results in denial of a Provider to participate in the Division's network, Provider termination, Provider suspension, or an action that

limits or restricts a Provider.

9. Submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) within 30 calendar days from the date the final Adverse Action was taken or by the close of the next monthly reporting cycle, whichever is later.

10. The Division shall immediately notify the AHCCCS Office of Inspector General (OIG) regarding any allegation of fraud, waste, or abuse of the AHCCCS Program, including allegations of fraud, waste, or abuse that were resolved internally but involved AHCCCS funds.

11. The Division shall provide notification regarding Credentialing denials to the applicable Provider(s) within 10 calendar days of the Credentialing Committee decisions.

12. The Division shall send a notice of final Adverse Action to AHCCCS/DHCM/QM within one business day and include the following information:

    a. The name and Tax Identification Number as defined in section 7701(A)(41) of the Internal Revenue Code of

1986[1121].

b. The name, if known, of any health care entity with which the health care Provider, supplier, or practitioner is affiliated or associated.

c. The nature of the final Adverse Action and whether such action is on appeal.

d. A description of the acts or omissions and injuries upon which the final Adverse Action was based, and such other information determined by regulation for appropriate interpretation of information reported under this section.

e. The date the final Adverse Action was taken, its effective date, and duration of the action.

f. Corrections of information already reported about any final Adverse Action taken against a health care Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

i. SAM, www.sam.gov, formerly known as the Excluded Parties List Syste;

ii. The Social Security Administration's Death Master File;

iii. The National Plan and Provider Enumeration System;

iv. List of Excluded Individuals or Entities; and

v. Any other databases directed by AHCCCS or CMS.

H. CREDENTIALING TIMELINESS

The Division's Credentialing Unit shall process Credentialing applications in a timely manner as shown in the following table:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Temporary/Provisional Credentialing	14 Days	100%
Initial Credentialing of Individual and Organizational Providers	60 Days	100%
Recredentialing of Individual and Organizational Providers	Every three years	100%
Load Times (Time between Credentialing Committee approval and loading into Claims System)	30 Days	95%

J. OVERSIGHT

1. The Division shall provide monitoring and oversight of the Division's Credentialing process through the following activities:

a. Review of quarterly performance data by the Quality Management/Performance Improvement (QM/PI) Committee.

b. Review of Credentialing data by the QM/PI Committee.

c. Recommendations by the QM/PI Committee regarding opportunities for improvement and monitor ongoing performance.

2. The Division shall monitor and provide oversight of the AdSS' Credentialing and recredentialing processes through annual operational reviews; review of quarterly reports submitted by the AdSS; and the internal quarterly health plan review meetings to ensure adherence to the requirements set forth in AdSS Medical Policy 950.

3. If there are any concerns regarding data reported in the quarterly reports by the AdSS, the Division may require the AdSS to report monthly until three consecutive months of compliance have been achieved.

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 10:20 PDT)
Anthony Dekker, D.O.

960 QUALITY OF CARE CONCERNS

REVISION DATES: 8/16/23, 6/29/22, 9/02/20, 12/18/19,

EFFECTIVE DATE: May 20, 2016

REFERENCES: AHCCCS Contract, AMPM Policies 961, 960, 950, 910, 320-U; Division Medical Policy 966; Division Operations Policies 407, 446; 9 A.A.C. 34, A.A.C. R9-19-314 B (13) and A.A.C. R9-19-315(E), R9-21-4, R9-21-101(B), R9-21-401 et seq., A.R.S. §§8-412(A), 12-901 et seq, 13-3620 36-664(H), 36-517.02, 36-664, 41-3801, 41-3804, 46-454, 42 CFR Part 2, 42 CFR 447.26, 42 CFR 431.300 et seq, 42 CFR 482.13(e)(1), 45 CFR 16.103, 20 U.S.C. §1232g

PURPOSE

This policy sets forth the Division of Developmental Disabilities' (Division) standards and requirements for reporting, evaluating, and resolving Quality of Care and service concerns raised by internal and external sources, including systemic concern. This policy also sets forth the Division standards for providing oversight of Member and Service Provider concerns and Quality of Care (QOC) Concerns.

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a Service Provider's practice by the Division.

2. "Health Care Acquired Condition" means a hospital acquired condition which occurs in any inpatient hospital setting and is not present on admission.

3. "High-Profile Case" means a case that attracts, or is likely to attract, attention from the public or media.

4. "Immediate Jeopardy" means a situation in which the Service Provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member.

5. "Incident, Accident, or Death" or "IAD" means an incident report entered into the Arizona Health Care Cost Containment System (AHCCCS) Quality Management (QM) Portal by a Service Provider to document an occurrence that caused harm or may have caused harm to a Member, or to report the death of a Member.

6. "Internal Referral" or "IRF" means a report entered into the AHCCCS

QM Portal by an employee of a health plan to document an occurrence that caused harm or may have caused harm to a member and or to report the death of a member.

7. "Investigation" means a collection of facts and information for the purpose of describing and explaining an Incident.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Other Provider Preventable Condition" means a condition occurring in an inpatient or outpatient health care setting which AHCCCS has limited to the following:

   a. Surgery on the wrong Member,

   b. Wrong surgery on a Member, and

   c. Wrong site surgery.

10. "Personally Identifiable Information" or "PII" means a person's name, address, date of birth, social security number, trial enrollment number, telephone or fax number, email address, social media identifier, driver's license number, places of employment, school identification or military identification number or any other distinguishing characteristic

that tends to identify a particular person as specified in A.R.S. § 41-3804(K).

11. "Protected Health Information" or "PHI" means individually identifiable information as specified in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

    a. Created or received by a health care provider, health plan, employer, or health care clearinghouse; and

    b. Relates to the past, present, or future physical or mental health condition of an individual, provision of health care to an individual.

12. "Provider-Preventable Condition" means a condition that meets the definition of a Health Care Acquired Condition or an Other Provider Preventable Condition.

13. "Quality Management" or "QM" means the evaluation and assessment which can be assessed at a Member, Service Provider, or population level of Member care and services to ensure adherence to standards of care and appropriateness of services.

14. "Quality Management/Performance Improvement Team" or "QM/PI" means Division staff who:

    a. Oversee the QOC Concern process;

    b. Evaluate Administrative Services Subcontractors' Quality Management/Performance Improvement Programs;

    c. Monitor and evaluate adherence with required quality and performance improvement standards through standardized Performance Measures, Performance Improvement Projects, and Quality Improvement specific Corrective Action Plans ; and

    d. Provides technical assistance for performance improvement related matters.

15. "Quality of Care" or "QOC" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provisions.

16. "Quality of Care Concern" or "QOC Concern" means an allegation that any aspect of care or treatment, utilization of behavioral health services, or utilization of physical health care services that d:

a. Caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition; and

b. May ultimately cause the risk of harm to a Member.

17. "Responsible Person" means the same as defined in A.R.S. § 36-551.

18. "Restraint" means personal restraint, mechanical restraint, or drug used as a restraint in a behavioral health inpatient setting as defined in 42 CFR 482.13(e)(1).

19. "Seclusion" means the involuntary confinement in a room or an area from which the person cannot leave.

20. "Seclusion of Individuals Determined to have a Serious Mental Illness" means the restriction of a behavioral health recipient to a room or area through the use of locked doors or any other device or method which precludes a person from freely exiting the room or area or which a person reasonably believes precludes the person's unrestricted exit as specified in A.A.C. R9-21-101(B).

a. In the case of an inpatient facility: confining a behavioral health recipient to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion.

b. In the case of a community residence, restricting a behavioral health recipient to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion, as specified in A.A.C. R9-21-101(B).

21. “Sentinel Event” means a Member safety event that results in death, permanent harm, or severe temporary harm.

22. “Service Provider" means the same as defined in A.R.S. § 36-551.

23. “Severity Levels” means the level of acuity of a QOC and which is described in the following ranking:

Level 0: (Track and Trend Only) - No Quality issue Finding

Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.

Level 2: Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.

Level 3: Quality issue exists with significant adverse effects on the patient/recipient; is dangerous or life-threatening.

Level 4: Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.

POLICY

A. DOCUMENTATION OF QUALITY OF CARE AND SERVICE CONCERNS

Upon receipt of a Quality of Care (QOC) or other form of concern regarding a service provided to a Member, the Division shall:

a. Document each concern raised, including the time and location of the event, if available, when and from whom it was received, and the projected time frame for resolution.

b. Determine which of the following processes will be used to resolve the concern:

i. Quality Management (QM) process,

ii. Grievance and appeals process,

iii. Both the grievance and appeals process and QM process if a rights violation also includes QOC,

iv. Process for making initial determination on coverage and payment issues, or

v. Process for resolving disputed initial determinations.

c. Provide written correspondence acknowledging receipt of the concern and explanation of the process to be used to resolve the QOC Concern.

d. If determined not to be a QOC Concern, provide an explanation of the process to be used to resolve the issue.

e. Provide assistance to the Member or Service Provider through the Office of Individual and Family Affairs, as needed, to complete forms or take other necessary actions to obtain resolution of the issue.

f. Maintain confidentiality of all Member information.

g. Inform the Member or Service Provider of all applicable mechanisms for resolving the concern external to the Division's processes.

h. Document all processes (including detailed steps used during the Investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance, or appeal, including:

i. Corrective action plan or action taken to resolve the concern;

ii. Documentation that education and training was completed, such as in-service attendance sheets and

training objectives;

iii. New policies and procedures; and

iv. Follow-up with the Member with the following as applicable to the situation:

1) Assistance to ensure that the immediate health care needs are met;

2) Closure or resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns; and

3) Referral to the Division's Compliance Unit or AHCCCS Office of the Inspector General.

i. Enter QOC Concerns received outside of the AHCCCS QM Portal as an Internal Referral within:

i. one business day for Sentinel Events; or

ii. Within two business days for all other reportable

Incidents.

ii. Comply with 9 A.A.C 34, Division Operations Policy 446, and the AHCCCS Contract for the grievance and appeal system for Members and Service Providers.

B. PROCESS OF EVALUATION AND RESOLUTION OF QOC AND SERVICE CONCERNS

1. The Division shall:
   a. Complete the QOC Concern Investigation and documentation process within the AHCCCS QM Portal; and
   b. Include a summary of all applicable research, evaluation, intervention, resolution, and remediation, including details for each case as a part of the documentation process.
2. The Division shall complete the QOC Investigation and documentation process as a stand-alone process through the Quality Management Unit (QMU) with assistance from other units when necessary.
3. The Division shall not combine the QOC Investigation process with other Division meetings or processes.
4. Work units outside of the QMU:

a. Shall not solely conduct QOC investigations.

b. Shall provide subject matter expertise throughout the investigative process as requested by the QMU.

5. The QMU shall be solely responsible for and conduct its own QOC Investigations for services rendered under its direct responsibility, including conducting onsite visits for QOC Concerns.

6. The Division shall evaluate and resolve QOC and service concerns by:

a. Identification of the QOC Concerns.

b. Initial assessment of the severity of each QOC Concern.

c. Referral of QOC Concerns that involve the network of subcontracted health plans to the specific health plan for Investigation and remediation.

d. Prioritization of actions needed to resolve immediate care needs when appropriate.

e. Identification of trends related to Members, Service Providers involved in the allegations, considering types and frequency of allegations, severity, and substantiation

status.

f. Research:

i. Fact-finding in accordance with Division Operations Policy 6002-F,

ii. Medical records review,

iii. Mortality review in accordance with Division Operations Policy 6002-M, and

iv. Incident closure and corrective actions in accordance with Division Operations Policy 6002-I.

7. The Division may request copies of a Member's death Certificate from the Arizona Department of Health Services Vital Records and Statistics as specified in A.A.C. R9-19-314 B(13) and A.A.C. R9-19-315(E).

8. The Division's Quality Management clinical staff shall conduct onsite visits when there are identified health and safety concerns, Immediate Jeopardy, or at the direction of AHCCCS. .

9. The Division shall report onsite visits that are identified and

conducted by the Division after 5:00 p.m. on weekdays, or that occur during weekends or on holidays, to the AHCCCS Division of Health Care Management (DHCM), Quality Management Manager or Supervisor by telephone and follow up with an email to CQM@AZAHCCCS.GOV the following business day.

10. Clinical Quality Management staff shall:
    a. Be the lead responsible for the review and Investigation, and
    b. Participate in the onsite visits.
11. Subject matter experts outside of the QMU:
    a. May participate in onsite visits when necessary and appropriate; but
    b. Shall not take the place of Quality Management staff during reviews.
12. The QMU shall complete and submit the AMPM 960 Attachment C form for each Health and Safety Onsite Review conducted to AHCCCS DHCM QM within 24 hours of completing the review as specified in Contract..
13. The Division shall,based on the findings of the review:

a. Take immediate action to ensure the health and safety of all Members receiving services at the facility or Service Provider site;

b. Ensure Incident resolution and identify any immediate care or recovery needs;

c. Develop work plans and corrective action plans to ensure placement setting or service site compliance with Arizona Department of Health Services Licensure and AHCCCS requirements regarding policy, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in AHCCCS Minimum Subcontract Provisions.

d. Conduct scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of Members, or as directed by AHCCCS.

e. Assist in identification of technical assistance resources focused on achieving and sustaining regulatory

compliance.

f. Determine, implement, and document all appropriate interventions including an action plan to reduce or eliminate the likelihood of the concern reoccurring.

g. Monitor and document success of interventions.

h. Monitor placement settings or service sites upon completion of activities and interventions to ensure compliance is sustained.

i. Implements new interventions and approaches when necessary.

j. Incorporate interventions into the Division's QM program plan if successful.

14. The QMU shall process investigations and resolution of Member and systemic concerns in a timely manner based on the nature and severity of each case or as requested by AHCCCS.

a. For high profile cases the QMU shall communicate initial reports of immediate findings to Division Executive

Leadership and AHCCCS DHCM QM immediately but no later than 24 hours of the QMU becoming aware of the concern and followed up by an initial findings report within seven business days.

b. For Member safety or placement concerns, the QMU shall schedule a due date for the resolution of the case for 30 calendar days from the date of opening.

c. For other concerns, the QMU shall schedule a due date for the resolution of the case within 60 calendar days from the date of opening.

d. The QMU shall track concerns that have aged to greater than 60 calendar days and develop action plans to address these cases.

e. The QMU shall coordinate with the Division Business Operations to review all paid claims within the last calendar year to identify the need to participate in systemic Investigations when notified of Service Provider concern related to:

i. Single case agreements, or

ii. Service Providers using subcontracted Service Providers.

15. The Division shall submit all requests for extensions of timelines associated with a QOC Investigation to AHCCCS DHCM QM for approval as soon as possible but no later than the assigned due date and include at a minimum:

    a. The Member's current placement and condition,

    b. The status of the Investigation, and

    c. The barrier to completing the Investigation within the assigned time frame.

16. The Division shall update the QM Portal due date after approval has been received from AHCCCS QM.

17. The Division shall, upon request from AHCCCS QM, provide additional information or attend a meeting to review the case and discuss barriers affecting the investigative process if more than one extension request is required to complete a QOC Investigation.

18. The QMU shall determine the level of severity of the QOC Concern initially based on the information received and the allegations involved, including whether Immediate Jeopardy is an issue.

19. The QMU shall ensure the case is updated to reflect changes in the Severity Level, as needed, during the Investigation as additional details and allegations are discovered and added to the QOC.

20. The QMU shall ensure that a final Severity Level is assigned to the case at the conclusion of the Investigation.

21. The QMU shall ensure that concerns are reported to the appropriate regulatory agency including:

    a. The Department of Child Safety,

    b. Adult Protective Services,

    c. Arizona Department of Health Services (ADHS),

    d. The Attorney General's Office,

    e. Law Enforcement,

f. AHCCCS Office of the Inspector General (OIG),

g. AHCCCS DHCM QM,

h. Other entities as necessary.

22. The QMU shall submit the initial report to the regulatory agency in the format required by the regulatory agency as soon as possible but no later than 24 hours of becoming aware of the concern.

23. The QMU shall submit all pertinent information regarding an Incident of abuse, neglect, exploitation, serious Incident including suicide attempts, and unexpected death including all unexpected transplant deaths, to AHCCCS DHCM QM as specified in Contract and Division Medical Policy 961.

    a. The QMU shall not limit pertinent information to autopsy results;

    b. The QMU shall include a broad review of all issues and possible areas of concern.

c. The QMU shall not delay the Division's Investigation of a QOC based on delays in receipt of autopsy results; Investigation of a QOC Concern.

d. The QMU shall, when available, use delayed autopsy results to confirm the resolution of the QOC Concern.

24. The QMU shall ensure qualified vendors follow procedures for reporting Incidents, Accidents and death as directed in Chapter 70 of the Provider Manual and Division Medical Policy 961.

a. QMU shall take any action necessary, upon receipt of an Incident, Accident, Death (IAD) Report from a Service Provider, to ensure the safety of the people involved in the Incident.

b. The QMU shall review the IAD Report within 24 hours of receipt and make a determination of whether the Incident includes a QOC Concern.

c. The QMU shall review the IAD Report to ensure it is fully and accurately completed.

i. If the IAD Report is not fully and accurately

completed, the QMU shall return the IAD Report to the Service Provider for correction.

ii. The QMU shall ensure that the Service Provider returns the corrected IAD Report within 24 hours of receipt.

25. The QMU Investigative Nurses shall determine the level of substantiation of the QOC during their Investigation.

26. The Division shall evaluate and resolve Service issues that do not rise to the level of a QOC Concern through the Customer Service Center or Support Coordination.

27. The QMU shall provide written notification to the appropriate regulatory board or licensing agency, and AHCCCS, when a health care professional, organizational provider, or other provider's affiliation with its network is suspended or terminated for any reason, including those related to QOC issues.

a. The QMU shall document all referrals made to a regulatory agency in the AHCCCS QM Portal and include, at minimum, the following information:

i. Name and title of the person submitting the report.

ii. Name of the regulatory agency the report was submitted.

iii. Name and title of the person at the regulatory agency receiving the report.

iv. Date and time reported.

v. Summary of the report.

vi. Tracking number, as applicable, received from the regulatory agency as part of the reporting process.

28. Division staff shall document in the QOC file all follow-up actions or monitoring activities, as well as related observations or findings.

29. In the event of a Service Provider suspension or termination, the Division Network and Support Coordination staff shall work in collaboration to assess and address Member needs impacted by the actionand work with Members to identify options and prepare for transition to new Service Providers.

C. TRAINING, INTER-RATER RELIABILITY FOR INCIDENT AND QOC REVIEW

1. The Division shall provide training to QMU staff on all new and updated policies and procedures.
2. The Division shall submit training documentation to AHCCCS that includes training materials, printed name and title of QMU staff, and date of training received.
3. QM clinical staff shall complete all required investigative training and achievement of competencies prior to performing Investigations.
    a. QM clinical staff responsible for conducting onsite investigations shall complete required training on how to conduct the Investigation and avoid interference with substantiation or prosecution.
    b. All QM clinical staff that may investigate alleged Incidents in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), skilled nursing facilities, assisted living facilities, and group homes for Individuals

with Intellectual Disabilities shall complete training on how to conduct Investigations considering the specific needs of individuals with intellectual and developmental disabilities.

c. The Division shall incorporate AMPM Policy 960 Attachment D guidance in the content requirements for training on Investigations involving individuals with intellectual and developmental disabilities.

4. All QM staff responsible for making determinations related to Incidents and QOC Concerns shall meet the requisite competencies and complete routine Inter-Rater Reliability (IRR) testing with a passing grade of 90 percent or higher.

a. QM staff who do not receive a passing grade of 90 percent or higher shall retake the exam.

b. The Division shall develop and implement an education plan for staff who do not receive a passing grade of 90 percent or higher on the repeat testing until a passing grade is achieved or the staff member is reassigned to a different position for which the training requirement is not

pertinent.

D. TRACKING AND TRENDING OF QOC AND SERVICE CONCERNS

1. The QMU shall conduct oversight through tracking and trending of Member and Service Provider concerns and making appropriate referrals for independent review as described in this section.
2. The QMU shall track and trend Member and Service Provider issues to identify and address quality assurance issues and opportunities for quality improvement.
3. The Division shall provide training to QMU staff on the process for analyzing QM related data.
4. The Division shall submit training documentation to AHCCCS that includes training materials, printed first and last name of QMU staff, title, and date of training received.
5. The QMU shall document, track, trend, and evaluate complaints and allegations received from Members and Service Providers, or as requested by AHCCCS, inclusive of quality care, Immediate Jeopardy, deaths, quality of service, and immediate care need issues.

6. The QMU staff and QM/PI Committee shall analyze and evaluate the information from the tracking and trending system to identify and address any trends related to Members, Service Providers, the QOC process or services in the Division's service delivery system or Service Provider network.
7. The QMU shall incorporate trending of QOC issues in determining systemic interventions for quality improvement.
8. The QMU shall submit for review and consideration for action tracking and trending information to the Division's Quality Management Committee and Chief Medical Officer, or designated Medical Director, as Chairman of the Quality Management Committee.
9. The QMU shall develop performance improvement activities based on input from Division Executive Leadership, the Division Chief Quality Officer, and the Division Chief Medical Officer to respond to significant negative trends, including the issue resolution process itself, and address other system issues raised during the resolution process.
10. The QMU shall share tracking and trending information related to

Service Provider education, training and staff credentialing with the workforce development operations as specified in Division Operations Manual Policy 407.

11. The QMU shall refer QOC Concerns identified through tracking and trending to the following committees as appropriate:

    a. QM/PI Committee established in accordance with Division Medical Policy 910,

    b. Peer Review Committee established in accordance with Division Medical Policy 910,

    c. Mortality Review Committee, and

    d. Independent Oversight Committees established by A.R.S. 41-3801.

12. The QMU shall comply with federal and state confidentiality laws, including the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq regarding Member record availability and accessibility.

13. The QMU shall maintain information related to coverage and payment issues for at least five years following resolution of the issue in accordance with Division Operations Manual Policy

6001-I, and is made available to the Member, Service Provider, and AHCCCS authorized staff upon request.

14. Support Coordination shall proactively facilitate care coordination for Members who have multiple complaints, regarding services or the AHCCCS Program. 15. Support Coordination shallwork with the Division's Office of Individual and Family Affairs or care coordination provided by the Administrative Services Subcontractors (AdSS) to facilitate and address Member complaints as a proactive measure to promote better service delivery and health outcomes.

15. QMU shall identify opportunities for improvement of care coordination in cases of multiple complaints from a single Member and monitor resolution of these complaints using tracking and trending data.

E. PEER REVIEW COMMITTEE

1. The QMU Chief Medical Officer shall refer cases, as appropriate, to the Division's Peer Review Committee.

2. The Peer Review Committee shall review the following:

   a. Cases where there is evidence of deficient quality by a

participating or non-participating physical or behavioral health care professional, or long-term services and supports (LTSS) Service Provider, whether delivered in or out of state.

b. Cases where there is omission of care or service that should have been provided by a participating or non-participating physical or behavioral health care professional, or Long Term Service and Support Service Provider, whether delivered in or out of state.

c. Oversight of the AdSS Peer Review Committee actions and remediations.

3. The Division shall not substitute referral to the Peer Review Committee for implementing interventions aimed at individual and systemic quality improvement.

4. The QMU shall document Peer Review referrals as well as high-level summary information in the QOC file within the AHCCCS QM Portal and include documentation of the specific credentials of the involved Committee members.

5. The Peer Review Committee may include the following recommendations as applicable:
   a. Education/training/technical assistance
   b. Follow-up monitoring and evaluation of improvement
   c. Changes in processes, organizational structures, forms
   d. Informal counseling
   e. Termination of affiliation, suspension, or limitation of the Service Provider
   f. Referrals to regulatory agencies
   g. Other actions as determined by the Division.
6. If an Adverse Action is taken with a Service Provider for any reason including those related to a QOC Concern, QMU shall report the Adverse Action, including limitations and terminations, to the AHCCCS DHCM Quality Management (QM) Unit as well as to the National Practitioner Data Bank as specified in Contract..
7. The QMU shall notify AHCCCS DHCM QM and take appropriate action with the Service Provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards,when an adverse outcome including mortalities due to

prescribing concerns or failure of the Service Provider to check the Controlled Substance Prescription Monitoring Program (CSPMP), to coordinate care with other prescribers, or to refer for substance use treatment or pain management is identified.

8. The QMU shall present case findings ,as appropriate, to the Division's Peer Review Committee and Credentialing Committee for review and recommendations to the QM/PI Committee for discussion and recommendations to leadership.

9. QM/PI Committee shall monitor the following related to QOC Concerns:

    a. Trending

    b. Corrective Action Plans

    c. Resolution

10. The Division's Medical Director:

    a. Shall be a member of the AdSS' Peer Review Committee, and

    b. Shall provide quarterly summaries of Service Providers s reviewed by the AdSS' Peer Review Committees to the

Division's Peer Review Committee.:

11. The Division's Peer Review Committee shall review the quarterly summaries of Service Providers reviewed by the AdSS to determine whether:

    a. The action taken by the AdSS Peer Review Committee is sufficient to protect Division Members, and

    b. If further action from the Division is necessary.

F. REPORTING TO INDEPENDENT OVERSIGHT COMMITTEES

1. The Division shall provide IAD Reports, Internal Referral (IRF) Reports, and QOC Concerns, including reports of possible abuse, neglect, or denial of rights involving any Division enrolled Member, to the Division's Independent Oversight Committee (IOC) assigned to the region in which the IAD, IRF, or QOC occurred within three business days of closure of the Incident.
2. The QMU shall incorporate IADs and IRFs that are triaged as potential QOC Concerns into the QOC record and submit to the IOC as part of the QOC documentation upon completion of the QOC Investigationinstead of a standalone IAD or IRF as specified in (1) of this section.

3. The QMU shall redact in accordance with federal and state confidentiality laws all Personally Identifiable Information (PII) in all reports provided to the IOC.
4. The Division shall provide the following reports to the IOC:
    a. Seclusion and Restraint Reports,
    b. IAD Reports,
    c. IFR Reports, and/or
    d. QOC Investigations as applicable.
    e. Reports of possible abuse, neglect, or denial of rights involving any behavioral health provider as specified in the contract.
5. The Division and contracted Service Providers who receive an IOC request for additional or unaltered documentation, supplemental information, or an Investigation regarding an AHCCCS Member, shall submit the request to AHCCCS via email at: iocinquiries@azahcccs.gov.
6. The Division shall provide to the AHCCCS Independent Oversight Committee assigned to the region in which the IAD, IRF, or QOC occurred AD Reports, IRF Reports, and QOC

Concerns, including reports of possible abuse, neglect, or denial of rights, involving any behavioral health provider serving Members with a Serious Mental Illness designation, children, and anyone under court order for either Court-Ordered Evaluation or Court-Ordered Treatment, are provided within three business days of closure.

F. REQUESTS FOR PERSONALLY IDENTIFIABLE INFORMATION OR PROTECTED HEALTH INFORMATION

1. The Division shall do the following if AHCCCS or an IOC requests information regarding the outcome of a report of possible abuse, neglect, or violation of rights:

   a. Conduct an Investigation of the Incident if one has not been conducted.

      i. For Incidents in which a Member with an Serious Mental Illness (SMI) designation is the possible victim, the Investigation follows the requirements specified in A.A.C. Title 9, Chapter 21, Article 4, or

      ii. For Incidents in which a currently or previously

enrolled child or non-seriously mentally ill adult is the possible victim, the Investigation is completed within 35 days of the request and shall determine, from all information surrounding the Incident, whether the Incident constitutes abuse, neglect, or a violation of rights, and any corrective action needed as a result of the Incident.

b. If an Investigation has been conducted, and can be disclosed without violating any confidentiality provisions, provide the final Investigation decision to AHCCCS and the IOC with the following information:

i. The accepted portion of the Investigation report with respect to the facts found,

ii. A summary of the Investigation findings, and

iii. Conclusions and corrective action taken.

2. The Division shall only release PII or PHI concerning a currently or previously enrolled Member to the IOC if:

a. The IOC demonstrates that the information is necessary to perform a function that is related to the IOC's oversight of the behavioral health system, or

b. The IOC has written authorization from the Responsible Party to review requested PII and PHI.

3. If the Division determines that the IOC needs PII or PHI or that the IOChas obtained the Responsible Party's written authorization, the QMU shall first review the requested information and determine if it contains any communicable disease-related information, including confidential Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) information, or information concerning diagnosis, treatment, or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804.

a. If no information detailed in (3) of this Section is found, the QMU shall provide the requested information to the IOC.

b. If information detailed in (3) of this Section is found, the

QMU shall contact the Responsible Person and ask if the Responsible Person is willing to sign an authorization for the release of communicable disease-related information, including confidential HIV information, or information concerning diagnosis, treatment or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804, and provide the name and telephone number of a contact person with the IOC who can explain the Committee's purpose for requesting the protected information.

i. If the Responsible Person agrees to give authorization, a written authorization is obtained as outlined below and requested information provided to the IOC.

ii. If the Responsible Person does not agree to give authorization, the information is not included or it is redacted from any documentation which is authorized to be disclosed.

4. The Division shall accept authorization for the disclosure of

records of deceased Members made by the executor, administrator, or other personal representative appointed by Will or by a court to manage the deceased Member's estate. If no personal representative has been appointed, the Division shall upon request disclose PII and PHI to a family member, other relative, or a close personal friend of the deceased Member, or any other person identified by the deceased, only that PII and PHI directly relevant to such person's involvement with the deceased Member's health care or payment related to the individual's health care.

5. The Division shall provide requested information that does not require authorization within 15 working days of the request.

6. The Division shall provide the requested information that does require authorization within five working days of receipt of the written authorization.

7. The QMU shall include a cover letter when PII or PHI is sent to the IOC that states that the information is confidential, is for the official purposes of the Committee, and is not to be re-released

under any circumstances.

8. If the QMU denies the IOC's request for PII or PHI:

   a. The QMU shall notify the IOC within five working days of the decision that a request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division's Deputy Director or designee review this decision.

   b. The Division shall only accept The Committee's request to review the denial if the request is received within 60 days of the first scheduled Committee meeting after the denial decision is issued.

   c. The Division's Assistant Director or designee shall conduct the review within five business days after receiving the accepted request for review.

   d. The Division shall consider the Division's Assistant Director or designee's decision the final agency decision pending any follow-up judicial review pursuant to A.R.S. Title 12,

Chapter 7, Article 6.

e. The Division shall not release related information or records related to the request during the timeframe for filing a request for judicial review or when judicial review is pending.

G. AUTHORIZATION REQUIREMENTS

1. The Division shall only accept a written authorization for disclosure of information concerning diagnosis, treatment, or referral from an alcohol or substance use program or communicable disease-related information, including confidential HIV information that contains the following information:

   a. The specific name or general designation of the program or person permitted to make the disclosure.

   b. The name or title of the individual or the name of the organization to which the disclosure is to be made.

   c. The name of the currently or previously enrolled Member.

   d. The purpose of the disclosure.

e. How much and what kind of information is to be disclosed.

f. The signature of the currently or previously enrolled Member/legal guardian, and if the currently or previously enrolled Member is a minor, the signature of a person authorized to give consent.

g. The date on which the authorization is signed.

h. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

i. The date, event, or condition upon which the authorization will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given.

j. A statement that this information has been disclosed to the recipient from records protected by federal confidentiality

rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the Member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H).

2. The Division shall track in accordance with the Record of Access described in Division Operations Manual Policy 6001-C information released pursuant to a valid authorization.

H. DUTIES AND LIABILITIES OF BEHAVIORAL HEALTH PROVIDERS IN PROVIDING BEHAVIORAL HEALTH SERVICES

The Division shall require the Administrative Services Subcontractors to develop policies and procedures that provide guidance to behavioral health providers regarding their duty to warn under A.R.S. §36-517.02.

I. PROVIDER-PREVENTABLE CONDITIONS

1. The Division shall not provide payment for services related to

Provider-Preventable Conditions pursuant to 42 CFR 447.26

2. The Division shall review the AdSS' required report for evidence of Provider-Preventable Conditions quarterly as described in the AdSS Medical Policy 960.

3. If Provider- Preventable Conditions are identified, the Division shall open a QOC Investigation within the AHCCCS QM Portal and direct the AdSS to conduct an Investigation if it has not already done so.

Signature of Chief Medical Officer: Anthony Dekker (Aug 10, 2023 17:31 PDT)
Anthony Dekker, D.O.

961 INCIDENT, ACCIDENT, AND DEATH REPORTING

REVISION DATE: 8/9/2023

EFFECTIVE DATE: May 11, 2022

REFERENCES: Division Medical Policies 960, 962, 1020, 1230-A; Division Operations Policy 417; A.R.S. §8-201(2), §14-1501, §36.551.01, §46-451, §41-3801, §41-3803, §41-3804; A.A.C. R9-10-101, R9-21-105.

PURPOSE

The purpose of this policy is to establish the requirements for the reporting, reviewing, and monitoring of Incident, Accident, Death (IAD) of Members enrolled with the Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a Member receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation,

incest, or prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

2. "AHCCCS" means Arizona Health Care Cost Containment System.
3. "Community Complaint" means a complaint from the community that puts a Member or the community at risk of harm.
4. "Death No Provider Present" means death of a Member living independently or with family and no Provider is being paid for service provision at the time of death.
5. "Expected Death" means a natural death, and may include deaths from long-standing, progressive medical conditions or age-related conditions.
6. "High Profile Case" means a case that attracts or is likely to attract attention from the public or media.
7. "Human Rights Violation" means a violation of a Member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the state of Arizona. Human rights are defined in A.R.S. §36.551.01 as a violation of a Member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat, etc.
8. "Incident, Accident, Death" means an unexpected occurrence that

harms or has the potential to harm a Member and is:

a. On the premises of a health care institution, or

b. Not on the premises of a health care institution and directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution as specified in A.A.C. R9-10-101.

9. "Independent Oversight Committee" is a committee established by State Statute to provide independent oversight and to ensure the rights of certain individuals with developmental disabilities and persons who receive behavioral health services are protected as defined in A.R.S. §§41-3801, 41-3803, 41-3804, and A.A.C. R9-21-105.

10. "Internal Referral" means, for the purpose of this policy, a report entered into the AHCCCS Quality Management Portal by an employee of the Division to document an occurrence that harms or has the potential to harm a Member, and to report the death of a Member.

11. "Medication Error" means that one or more of the following has occurred:

a. Medication given to the wrong person,

b. Medication given at the wrong time or not given at all,

c. Wrong medication dosage administered,

d. Wrong method of medication administration, or

e. Inappropriate wastage of a Class II substance.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

13. "Physical Abuse" means intentional infliction of pain or injury to a Member.

14. "Programmatic Abuse" means aversive stimuli techniques not approved as part of a member's plan. This can include isolation, restraints, or not following an approved plan or treatment strategy.

15. "Provider" means, for the purpose of this policy, any individual or entity that is engaged in the delivery of services to Division Members, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

16. "Sentinel Event" means an unexpected event that results in the death of a member, serious physical injury of a member, or severe psychological harm of a member, and requires an immediate investigation and response.

17. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, such as assessment or treatment in an

emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

18. "Sexual Abuse" means any inappropriate interactions of a sexual nature toward or solicited from a Member with developmental disabilities.

19. "Unexpected Death" means a sudden death and may include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma, sudden deaths from undiagnosed conditions, or generic medical conditions that progress to rapid deterioration.

20. "Verbal/Emotional Abuse" means remarks or actions directed at a Member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory, or profane.

POLICY

A. MINIMUM REQUIREMENTS FOR IAD REPORTING

1. The Division shall submit reportable Incident, Accident, Death (IAD), and Internal Referrals to AHCCCS via the AHCCCS Quality Management (QM) Portal within two business days of the occurrence or notification of the occurrence.

2. The Division shall submit Sentinel IADs to AHCCCS via the AHCCCS QM Portal within one business day of the occurrence or notification of the occurrence.

3. The Division shall notify AHCCCS of all Sentinel Events via email at CQM@ahcccs.gov as soon as possible, but within 24 hours of notification of the occurrence.

4. The Division shall consider the following to be reportable IADs:

    a. Allegations of abuse, neglect, or exploitation of a Member.

    b. Allegations of Human Rights Violations.

    c. Substance use disorders and opioid-related concerns.

    d. Death of a Member.

    e. Delays or difficulties in accessing care outside of the timeline specified in Division's Operations Policy 417.

    f. Healthcare acquired conditions and other provider preventable conditions as specified in Division Medical Policy 960.

    g. Serious Injury.

    h. Injury resulting from the use of a personal, physical, chemical or mechanical restraint, or seclusion as specified

in Division Medical Policy 962.

i. Medication Error occurring at a licensed residential Provider site including:

i. Division Group Home,

ii. Division Adult Developmental Home,

iii. Child Developmental Home,

iv. Assisted Living Facility,

v. Skilled Nursing Facility,

vi. Behavioral Health Residential Facility,

vii. Adult Behavioral Health Therapeutic Home,

viii. Therapeutic Foster Care Home, or

ix. Any other alternative Home and Community Based Service setting as specified in Division Medical Policy 1230-A.

j. Missing Member from a licensed Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, Division Group Home, Assisted Living Facility, Skilled Nursing Facility, Intermediate Care Facility, Adult Behavioral Health Therapeutic Home, or Therapeutic Foster Care.

k. Member suicide attempt.

l. Suspected or alleged criminal activity involving or affecting a Member.

m. Community Complaint about a resident or the setting.

n. Provider or Member fraud.

o. Allegations of Physical, Sexual, Programmatic, Verbal/ Emotional Abuse.

p. Allegations of inappropriate sexual behavior.

q. Theft or loss of Member monies or property less than $1,000.

r. Property damage estimated to be less than $10,000.

s. Community disturbances in which the Member or the public may have been placed at risk.

t. Environmental circumstances which pose a threat to the health, safety, or welfare of Members, such as loss of air conditioning, loss of water, or loss of electricity.

u. Unplanned hospitalization or emergency room visit in response to an illness, injury, Medication Error.

v. Unusual weather conditions or other disasters resulting in an emergency change of operations impacting the health

and safety of a Member.

w. Illegal substance use by Provider or Member.

x. Any other incident that causes harm or has the potential to cause harm to a Member.

2. The Division shall consider the following to be reportable IAD Sentinel Events:

a. Member death or Serious Injury associated with a missing Member.

b. Member suicide, attempted suicide, or self-harm that results in Serious Injury while being cared for in a healthcare setting.

c. A 9-1-1 call due to a suicide attempt by a Member.

d. Member death or Serious Injury associated with a Medication Error.

e. Member death or Serious Injury associated with a fall while being cared for in a healthcare setting or any other setting where the Division has oversight responsibility.

f. Any stage 3, stage 4, or any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting.

g. Member death or Serious Injury associated with the use of seclusion or restraint while being cared for in a healthcare setting.

h. Sexual Abuse or assault of a Member during the provision of services.

i. Death or Serious Injury of a Member resulting from a physical assault that occurs during the provision of services.

j. Homicide committed by or allegedly committed by a Member.

k. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a Member or staff.

l. Severe physical injury that does any of the following:

   i. Creates a reasonable risk of death,

   ii. Causes serious or permanent disfigurement, or

   iii. Causes serious impairment of a Member's or worker's health.

m. Reporting to law enforcement officials because a Member is missing and presumed to be in imminent danger.

n. Reporting to law enforcement officials due to possession or use of illegal substances by Members or Providers.

o. An incident or complaint from the community that could be or is reported by the media.

p. Property damage estimated in excess of $10,000.

q. Theft or loss of Member monies or property of more than $1,000.

B. QUALITY MANAGEMENT RESPONSIBILITIES

1. The Quality Management Unit (QMU) shall conduct an initial review of all IADs within one business day of Provider submission. An initial review shall include the following:

   a. Identification of any immediate health and safety concerns and ensure the safety of the individuals involved in the incident, which may include that immediate care and recovery needs are identified and provided.

   b. Determination if the IAD report needs to be returned to the Provider for additional information, to correct inaccurate information, or to provide missing information.

   c. Determination if the IAD report requires further

investigation through a quality of care investigation as specified in Division Medical Policy 960.

d. Determination if the IAD needs to be linked to a corresponding Seclusion and Restraint Individual Reporting Form.

e. Determination that the report does not need further documentation or review, and closure of the report.

2. The QMU shall follow up on all IADs returned to a Provider within one business day to ensure the Provider is aware that the report has been returned and is addressing the required corrections.

3. The QMU shall take immediate action to ensure the safety of Members where allegations of harm or potential harm exist, regardless of status assigned to the IAD, including those returned to the Provider.

4. The QMU shall report all suspected cases of abuse, neglect, or exploitation of a Member to the appropriate reporting authorities if not reported directly by the Provider, as specified in Division Operations Policy 6002-G.

5. The QMU shall track and trend IADs to identify and address

systemic concerns or issues within its Provider network.

6. The QMU shall provide IAD reports to the appropriate Independent Oversight Committees, as applicable, and as specified in Division Medical Policy 960 and A.R.S. 41-3801 et seq.

C. DIVISION OVERSIGHT AND MONITORING OF ADSS

1. The Division shall monitor the AdSS' compliance of the requirements set forth in AdSS Medical Policy 961 through AdSS' tracking and trending reports submitted to the Division.
2. The Division shall also conduct Annual AdSS Operational Reviews to ensure compliance to AdSS Medical Policy 961 and associated procedures.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 13:19 PDT)
Anthony Dekker, D.O.

962 REPORTING AND MONITORING OF SECLUSION AND RESTRAINT

REVISION DATE: 8/9/2023
EFFECTIVE DATE: September 14, 2022
REFERENCES: A.A.C. R9-10-101, R9-10-225, R9-10-226, R9-10-316, R9-10-1012, R9-21-101, R9-21-204; A.R.S. §36- 501, §41-3804 (K); 42 CFR 482.13(e)(1)(i)(B), AHCCCS Medical Policies 961 and 960

PURPOSE

To set forth the requirements applicable to the Division of Developmental Disabilities (Division) to provide oversight and monitoring of Seclusion and Restraint reporting for Members served by the Division, regardless of their health plan enrollment, in all state licensed Behavioral Health Inpatient Facilities, Mental Health Agencies, and out-of-state facilities providing behavioral health services to Division Members.

DEFINITIONS

1. "Behavioral Health Inpatient Facility" means, as defined in A.A.C. R9-10-101, a health care institution licensed by the Arizona Department of Health Services that provides continuous treatment to individuals experiencing behavioral health issues that causes that

individual to:

a. Have a limited or reduced ability to meet basic physical needs;

b. Suffer harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self or others;

d. Be persistently or acutely disabled as defined in A.R.S. §36-501; or

f. Be gravely disabled.

2. "Incident of Seclusion and Restraint" means an occurrence of Seclusion or Restraint that begins at the time a behavior necessitating Seclusion or Restraint begins and ends when the behavior has resolved for more than ten minutes.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Mental Health Agency" means a regional authority, service provider, inpatient facility, or outpatient treatment center licensed to provide behavioral health observation/stabilization services (Crisis Facility), licensed to perform Seclusion and Restraint as specified in A.A.C. R9-10-225, A.A.C. R9- 10-226, A.A.C. R9-10-316 and A.A.C. R9-10-1012.

5. “Personally Identifiable Information” means a person's name, address, date of birth, social security number, tribal enrollment number, telephone or fax number, email address, social media identifier, driver license number, places of employment, school identification or military identification number, or any other distinguishing characteristic that tends to identify a particular person as specified in A.R.S. §41-3804 (K).
6. “Restraint” means personal Restraint, mechanical Restraint, or drug used as a Restraint, and is the following:
    a. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a Member to move their arms, legs, body, or head freely.
    b. A drug or medication when it is used as a restriction to manage a Member’s behavior or restrict the Member’s freedom of movement and is not a standard treatment or dosage for the Member’s condition as specified in 42 CFR 482.13 (e)(1)(i)(B). Chemical Restraints shall be interpreted and applied in compliance with the Center for Medicaid Services (CMS) State Operations Manual, Appendix A at A-0160 for Regulations and

Interpretive Guidelines for Hospitals.

c. A Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a Member for the purpose of conducting routine physical examinations or tests, or to protect the Member from falling out of bed or to permit the Member to participate in activities without the risk of physical harm. This does not include a physical escort.

7. "Seclusion" means the involuntary solitary confinement of a Member in a room or an area where the Member is prevented from leaving as specified in A.A.C. R9-10-101.

8. "Seclusion of Members Determined to Have A Serious Mental Illness" means the restriction of a Member to a room or area through the use of locked doors, or any other device or method which precludes a Member from freely exiting the room or area, or which a Member reasonably believes precludes their unrestricted exit.

a. In the case of an inpatient facility, confining a Member to the facility, the grounds of the facility, or a ward of the facility does

not constitute Seclusion.

b. In the case of a community residence, restricting a Member to the residential site, according to specific provisions of a service plan or court order, does not constitute Seclusion, as specified in A.A.C. R9-21-101(B).

POLICY

A. SECLUSION AND RESTRAINT

1. The Division shall require that the use of Seclusion and Restraint (SAR) be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R910-316, and A.A.C. R9-21-204.
2. The Division shall require that any incident involving the use of SAR be reported as described in this policy to the Arizona Health Care Cost Containment System (AHCCCS), Division of Community Advocacy and Intergovernmental Relations, Office of Human Rights, and the appropriate Independent Oversight Committee (IOC) via collaboration with the AHCCCS Division of Health Care Management, Quality Management (QM) IOC Manager.

3. The Division shall require all interventions used during each incident of SAR be documented in a single individual report including all required components of each type of intervention used to manage the behavior.

B. DIVISION OVERSIGHT AND MONITORING OF REPORTING REQUIREMENTS

1. The Division shall require the AdSS to follow the reporting requirements as specified in this policy.

2. The Division shall require the AdSS utilizing any out-of-state facility to provide behavioral health services to Division Members, to ensure the facility agrees to and follows all reporting requirements as specified in AdSS Medical Policy 962 as a part of the contracted single case agreement.

3. The Division shall require the AdSS to submit individual reports of Incidents of SAR involving Division Members directly to the AHCCCS QM Portal within five business days of the incident using AMPM Policy 962 Attachment A or the agency's electronic medical record that includes all elements listed on AMPM Policy

962, Attachment A. If the use of SAR requires face-to-face monitoring, as specified in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to the individual report.

4. The Division shall require the AdSS to have a process in place to ensure incidents of SAR that result in an injury or complication requiring medical attention are reported to the AdSS within 24 hours of the incident.

B. SUBMITTING INDIVIDUAL REPORTS OF SAR TO THE AHCCCS QM PORTAL

1. The Division shall review all individual reports of SAR submitted through the AHCCCS QM Portal by the AdSS and their service providers as specified in contract.

2. The Division shall ensure that the original AMPM 962 Attachment A or electronic medical record received from the service provider is attached to the record within the AHCCCS QM Portal.

3. The Division shall ensure individual reports of SAR are linked to any connected Incident, Accident or Death (IAD), Internal

Referral (IRF), or Quality of Care (QOC) Concern process within the AHCCCS QM Portal as specified in Division Medical Policy 960.

C. SUBMITTING INDIVIDUAL SAR REPORTS TO THE IOC

1. The Division shall ensure that all individual SAR Reports involving behavioral health service providers are uploaded within the AHCCCS QM Portal for IOC review as specified in contract.

2. The Division shall ensure that all reports uploaded for IOC review have all Personally Identifiable Information removed prior to submission as specified in A.R.S. §41-3804. If the use of SAR requires face-to-face monitoring, as outlined in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to each individual report.

3. The Division shall ensure that the disclosure of protected health information is in accordance with state and federal laws.

D. OVERSIGHT, MONITORING, TRACKING AND TRENDING

1. The Division's Quality Management Unit (QMU) shall monitor the

AdSS' compliance to these reporting standards and AdSS Medical Policy 962 through review of SAR reports entered in the AHCCCS QM Portal and during the annual review process.

2. The Division's QMU shall track and trend the use of SAR for all Members, including Members at the Arizona State Hospital, and prepare quarterly reports for the Quality Management/Performance Improvement (QM/PI) Committee based on the data.

3. The QM/PI Committee shall review the quarterly reports, SAR incidents and recommendations for improvement, and develop recommendations to ensure Member safety and quality improvement.

4. The QM Medical Director shall review any QOC Concerns involving the inappropriate use of SAR on a monthly basis and identify opportunities for improvement and make recommendations to the Chief Medical Officer.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 12:37 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

1. The AHCCCS OHR and the IOCs review SAR reports to determine if there has been inappropriate or unlawful use of SAR and to determine if SAR may be used in a more effective or appropriate fashion.
2. If the AHCCCS OHR or any IOCs determine that SAR has been used in violation of any applicable law or rule, the OHR or IOC may take whatever action is appropriate in accordance with their applicable regulation(s) and, if applicable, A.A.C. R9-21-204.
3. AHCCCS requires BHIFs and Mental Health Agencies providing services to FFS Members, except THP Members enrolled to receive behavioral health services with a Regional Behavioral Health Agency, submit individual SAR reports directly to the AHCCCS DCAIR OHR via email at OHRts@azahcccs.gov and to the AHCCCS DHCM QM IOC Manager using AMPM 962 Attachment A or the agency's electronic medical record that includes all elements listed on Attachment A concerning the use of SARs involving Members with a Serious Mental Illness designation within five business days of the occurrence of the incident. If the use of SARs requires face-to-face monitoring, a supplemental report shall be submitted as an attachment to each individual report.

966 IMMEDIATE JEOPARDY

EFFECTIVE DATE: April 20, 2022

REFERENCES: AMPM Chapter 900, Policy 960, Division Medical Manual Policy 960, 950, AdSS Medical Manual Policy 960

Purpose

This policy establishes the requirements applicable to the Division of Developmental Disabilities (Division) when the Arizona Health Care Cost Containment System (AHCCCS) notifies the Division with a report of immediate jeopardy (IJ), or the Division becomes aware of a situation that may elevate to the level of immediate jeopardy.

Scope

This policy applies to the Division's activities in investigating and resolving incidents involving allegations of immediate jeopardy.

Definitions

Immediate Jeopardy **-** A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a member. An immediate jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

Emergency Measure - The use of physical management techniques (Prevention and Support Intervention Techniques) in an emergency to manage a sudden, intense, or out of control behavior.

Policy

The Division ensures the health, well-being and safety of all members where a situation may present as immediate jeopardy. The Division takes action to remediate/remove any immediate jeopardy situation.

A. AHCCCS Notification of Immediate Jeopardy

1. During Normal Business Hours.

AHCCCS sends an email to the Division Quality Management Unit (QMU) mailbox and Chief Medical Officer, Chief Quality Officer and/or their designee, which details an immediate jeopardy situation. Notification of the immediate jeopardy situation requires the QMU team to conduct an investigation to determine member(s) status and remediate the IJ situation immediately but no later than 24-hours after the IJ notification. In the event other Division departments are involved with the Immediate Jeopardy situation, the QMU team holds ultimate accountability for resolving the IJ issue within the 24-hour timeframe. The following steps occur when an IJ is reported to the QMU:

a. QMU staff determines and verifies whether the situation impacts Division member(s) and/or provider(s).

b. Once verification is determined that Division member(s) are involved, QMU schedules an immediate health/safety monitoring visit within 24 hours. The Division notifies AHCCCS of the identity of the members involved.

c. QMU responds to AHCCCS on the member status based upon the monitoring report using the immediate jeopardy form (AHCCCS Medical Policy Manual [AMPM] 960 Attachment C Health and Safety Update Onsite Review Form) within the 24-hour timeline.

d. QMU notifies relevant Division staff and Department chain-of-command, as appropriate and required.

e. Information regarding any findings from the visit are forwarded to QMU as soon as the visit is completed using 960 Attachment C Health and Safety Onsite Review Form. The Incident Specific Health and Safety Assessment form is completed for each member identified in the incident report and in addition to other required information specifies the immediate steps taken to secure the safety of the resident.

f. If the immediate jeopardy situation affects Division member(s) in an acute care funded facility, the Division-contracted Administrative Services Subcontractor (AdSS) plan is notified to complete steps a, b, and e and send the response to the QMU to assess and respond to AHCCCS within 24-hours.

g. If the IJ situation arises late in the business day, the District on-call person is notified that they may be receiving a report after hours. In the event the District on-call person believes the immediate jeopardy team needs to convene, they will call the Chief Quality Officer (CQO) or designee and the CQO will initiate the call tree.

2. After Normal Business Hours.

The Division's After Hours staff contacts the District on call staff with any reports of immediate jeopardy that require follow-up within 24-hours. The designated staff on call in each District will contact the QMU Chief Quality Officer or their designee to initiate coordination of immediate jeopardy investigation and follow-up to include steps 1 a-e listed above.

B. Division Identification of Immediate Jeopardy

1. During Normal Business Hours.

When the Division becomes aware of an immediate jeopardy situation from any source involving Division members, QMU staff assume responsibility of the IJ situation/issue. In the event other Division departments are involved with the

Immediate Jeopardy situation, the QMU team holds ultimate accountability for resolving the IJ issue within the 24-hour timeframe. The following steps are completed within 24-hours of notification/identification of the immediate jeopardy situation:

a. QMU staff determines and verifies whether the situation affects Division member(s) and/or provider(s).

b. Once verification is determined that a Division member(s) are involved, QMU schedules an immediate health/safety monitoring visit within 24 hours. The Division notifies AHCCCS of the identity of the members involved.

c. QMU reports to AHCCCS the immediate jeopardy situation, on the members impacted and the member status based upon the monitoring report using the immediate jeopardy form (AMPM 960 Attachment C Health and Safety Update Onsite Review Form) within the 24-hour timeline.

d. QMU notifies relevant Division staff and Department chain-of-command, as appropriate and required.

e. Information regarding any findings from the visit are forwarded to QMU as soon as the visit is completed using 960 Attachment C Health and Safety Onsite Review Form. The Incident Specific Health and Safety Assessment form is completed for each member identified in the incident report and in addition to other required information specifies the immediate steps taken to secure the safety of the resident.

f. If the immediate jeopardy situation affects Division member(s) in an acute care funded facility, the Division-contracted AdSS is notified to complete steps a-c and send the response to the QMU to assess and respond to AHCCCS within 24-hours.

g. If the IJ situation arises late in the business day, the District on-call person is notified that a report may be sent after hours. In the event the District on-call staff believes the immediate jeopardy team needs to convene, the staff will call the Chief Quality Officer (CQO) or designee and the CQO will initiate the call tree.

3. After Normal Business Hours.

The District on call staff receives any reports of immediate jeopardy that require follow-up within 24 hours. The on-call staff in the District contacts the QMU CQO or their back-up to hand off coordination of follow-up for the immediate jeopardy notifications to include steps a-e listed above.

C. Member Relocation from Residential Facility

1. When certain serious conditions are present at residential facilities, the Division offers relocation options to members to ensure their health and safety. This section describes the following:

    a. The types of facilities where members reside that may be subject to relocation.

    b. The types of presenting circumstances that may support a decision to relocate member(s).

    c. The decision makers authorized to make the determination to relocate members.

2. The types of residential facilities from which members may be subject to relocation under this policy include the following:

    a. Group Homes

    b. Nursing Supported Group Homes

    c. Intermediate Care Facilities (ICFs)

    d. Adult Developmental Homes (ADHs)

    e. Child Developmental Homes (CDHs)

3. The Division may elect to relocate members for the following reasons including but not limited to:

    a. An individual is injured or ill and has not received medical attention.

    b. Air conditioning or heating units are not working and the thermostat at the facility is above 90 degrees Fahrenheit on high temperature days or below 60 degrees Fahrenheit on cold temperature days.

    c. The water or electricity is not working or has been shut off.

    d. The staff to client ratio is not adequate to meet the needs of the individuals in the home. For example, a resident requires a two person lift and there is only one staff on duty; a resident requires 1:1 staffing according to their Service plan and there is insufficient staffing to meet the requirement.

    e. On-duty staff is unable to meet the needs of residents due to being under the influence of alcohol or drugs.

    f. Staff lack required initial training or have not been oriented to client needs, placing residents at risk.

    g. Indications of physical abuse, sexual abuse and/or neglect of residents is evident.

h. Resident expresses fear about remaining in the facility.

i. Environmental health and safety risks are present. For example, fire damage, fire hazards such as exposed wiring, unsecured pool area, doors/windows cannot be secured, blocked doorways or unhealthy living conditions.

j. Food supplies are inadequate. There must be sufficient food to prepare a well-balanced dinner, breakfast the next morning and to pack lunches for the next day. Only if the provider is unable or unwilling to immediately remediate this issue would residents be relocated.

k. Provider license is suspended, expired, or voluntarily surrendered.

l. Serious infestation in the facility of insects or rodents.

m. The facility has non-working appliances such as a stove or refrigerator.

n. The residents do not have adequate furniture.

4. A Network Manager, District QI Manager, QMU Administrator, DDD Contracts Administration Unit staff or members of the Executive Leadership Team are responsible for making the determination to relocate members from residential facilities and documented in a summary note in FOCUS/Incident Management System (IMS).

D. Timeframes for Response

1. Below are standard expected response times for face-to-face visits with the member and/or purposeful site visits to the place of occurrence to determine whether there are site safety concerns related to allegations of immediate jeopardy. The types and categories below are not an exclusive list and the Quality Assurance Manager and/or Supervisor may exercise discretion to dispatch staff for a site visit that is not listed below.

2. Response within 24 hours of notification:

a. Unexpected death

b. Accidental injury with hospitalization

c. Neglect with imminent danger

d. Attempted suicide with serious injury

e. Physical or sexual abuse with serious injury

f. Emergency measures utilizing a prohibited restraint

g. Emergency measure with serious injury

h. Physical or sexual abuse (without serious injury)

i. Neglect with potential danger

j. Medication error with hospitalization

k. Human rights violation allegation

l. Injury of unknown origin

m. Programmatic abuse allegation

n. Verbal/emotional abuse allegation

o. Unapproved (but not prohibited) emergency measure without serious injury

E. Investigation, Evaluation and Resolution of Immediate Jeopardy Findings

1. The Division complies with Division Medical Policy 960 Quality of Care (QOC) Concerns for investigating, reviewing, evaluating, monitoring, and resolving all QOC concerns including concerns that involve allegations of immediate jeopardy.

2. The District nurse investigator takes prompt action to ensure the health, safety and well-being of the member(s) including remaining with the member(s) until the risk of harm or likelihood for serious harm is remediated.

3. Based on the findings of the investigation of an Immediate Jeopardy situation, in accordance with Division Medical Policy 960, the Division may implement any or all the following:

a. Actively participate in meetings focused on ensuring incident resolution and health and safety of members, as well as identifying any immediate care or recovery needs.

b. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service site compliance with Arizona Department of Health Services (ADHS) Licensure, Division contract requirements, and/or AHCCCS requirements, including, but not limited to, policy, training and signage requirements aimed at preventing and reporting abuse, neglect and exploitation as specified in AHCCCS Minimum Subcontract Provisions.

c. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an immediate jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS.

d. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.

e. Monitor placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

f. Initiate corrective actions that may include sanctioning the provider or other appropriate contract actions to ensure client safety and provider response.

g. Take adverse action against the credentialing or contract status of a provider pursuant to Division Medical Policy 950.

4. The Division tracks immediate jeopardy incidents to identify trends and determine systemic interventions and opportunities for quality improvement.

a. The Division tracks the timeliness of its response to quality of care concerns and complaints involving allegations of immediate jeopardy. The timeframes for response set forth in this policy at Section D. 3-5 are tracked and trending to identify member/provider systemic issues. The following are tracked:

i. Number and reason for failure to respond within designated timeframes.

ii. Number and types of corrective actions per complaint type.

iii. Number and types of notifications to outside agencies including, but not limited, to law enforcement, Adult Protective Services, Department of Child Services, Arizona Department of Health Services.

b. Findings from investigations are also tracked and trended, including whether the allegations are substantiated, unsubstantiated, or unable to substantiate. Categories of findings that are tracked may include, but are not limited to:

i. Quality of care/treatment

ii. Member neglect

iii. Member rights

iv. Physical environment

v. Member abuse

vi. Other

c. The results of the Division's tracking and trending for immediate jeopardy related data are analyzed, reviewed, and discussed, at the monthly Quality Management subcommittee meeting, the monthly Performance Improvement Monitoring Subcommittee

meeting, and the quarterly Quality Management Program Improvement (QMPI) Committee for discussion and any decision-making with senior leadership.

Signature of Chief Medical Officer: Anthony Dekker
Anthony Dekker (Apr 15, 2022 13:15 PDT)
Anthony Dekker, D.O.

970 PERFORMANCE MEASURES

REVISION DATES: 9/6/23, 3/9/22, 07/29/20, 11/17/17

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 CFR 438 and AHCCCS Medical Policies 920 and 970

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) to Evaluate, monitor, and report on performance measures; responsibilities related to performance measures specific to Long-Term Services and Supports; and oversight of physical and behavioral health services performance measures delegated to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. “Evaluate” means the process used to examine and determine the level of quality or the progress toward improvement of quality or performance related to service delivery systems.
2. “Health Information System” means a primary data system that collects, analyzes, integrates, and reports data to achieve the Objectives outlined under 42 CFR 438, and data systems composed of the resources, technology, and methods required to optimize the

acquisition, storage, retrieval, analysis, and use of data.

3. "Inter-Rater Reliability" means the process of ensuring that multiple observers are able to consistently define a situation or occurrence in the same manner, which is then recorded.
4. "Long-Term Services and Supports" means services and supports provided to Members who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice as specified in 42 CFR 438.2.
5. "Measurable" means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive outcome.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive outcome.
8. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities and documenting results via desktop or onsite review.

9. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
10. "Official Rates" means Performance Measure results calculated by the Division that have been validated by the AHCCCS External Quality Review Organization for the calendar year.
11. "Outcome" means a change in patient health, functional status, satisfaction, or goal achievement that results from health care or supportive services [42 CFR 438.320].
12. "Performance Improvement" means the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent or systemic problems or barriers to improvement.
13. "Performance Measure Performance Standards" means the minimal expected level of performance based upon the National Committee for Quality Assurance, HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services Medicaid Median for selected Core Set-Only Measures, as identified by the Arizona Health Care Cost Containment System (AHCCCS), as well as the Line of Business aggregate rates, as

applicable.

14. "Plan-Do-Study-Act Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period the approach is known as Rapid Cycle Improvement. The PDSA Cycle consists of the following steps:

    a. Plan: Plan the changes or interventions, including a plan for collecting data. State the Objectives of the interventions.

    b. Do: Try out the interventions and document any problems or unexpected results.

    c. Study: Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

    d. Act: Refine the changes or interventions based on what was learned and prepare a plan for retesting the interventions

    e. Repeat: Continue the cycle as new data becomes available until improvement is achieved.

13. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.

14. "Triple Aim" means a framework for optimizing health system performance consisting of the following three components:

    a. Improve the experience and outcomes of care;

    b. Improve the health of populations; and

    c. Reduce the per capita costs of healthcare.

POLICY

The Division's management of performance measures is focused on achieving the goals of the Triple Aim, providing integrated care, identifying and standardizing best practices, implementing targeted interventions, and tracking and trending outcomes to support quality improvement in member health and well-being.

A. PERFORMANCE MEASURES

1. The Division's Quality Management Unit (QMU) shall use standardized performance measures that focus on the following clinical and non-clinical areas reflective of the Centers for Medicare and Medicaid Services (CMS) Core Set domains of care:

    a. Primary Care Access and Preventive Care;

    b. Maternal and Perinatal Health;

c. Care of Acute and Chronic Conditions;

d. Behavioral Health Care;

e. Dental and Oral Health Services;

f. Experience of Care; and

g. Long-Term Services and Supports (LTSS).

2. The Division shall collect, monitor, and Evaluate Health Information System data relevant to the following performance measures:

a. Quality,

b. Timeliness,

c. Utilization,

d. Efficiency,

e. Member satisfaction,

f. Targeted investment, and

g. Performance Improvement.

3. The Division's Quality Management Unit (QMU) shall analyze, monitor, and Evaluate established performance metrics on an on-going basis and develop specific Measurable goals and Objectives aimed at supporting quality management and desired outcomes as well as enhancing the Quality Management/Performance Improvement (QM/PI) Program.

4. The QMU shall self-report the following performance metrics to AHCCCS:

   a. Quality Management/Quality of Care;

   b. Medical Management;

   c. Maternal and Child Health;

   d. Network Adequacy; and

   e. Waiver/Program Evaluation.

5. The Division shall include LTSS specific performance measures that examineMembers' quality of life, community integration activities [42 CFR 438.330©(1)(ii)], and any performance measures that are the responsibility of the AdSS.

B. PERFORMANCE MEASURE REQUIREMENTS

1. The QMU shall oversee activities delegated to the AdSS associated with performance measures.

2. The QMU shall work collaboratively with the AdSS to ensure that the AdSS are achieving performance measure standards as part of the quality management plan.

3. The QMU shall ensure compliance with AHCCCS QM/PI requirements and the utilization of applicable performance measure methodologies for internal Monitoring and evaluation of performance measure results.

4. The QMU shall provide oversight to ensure that the AdSS:

    a. Adhere to the requirements related to performance measures.

    b. Utilize the results of the Official Rates in evaluating the AdSS QM/PI Program.

    c. Achieve the Performance Measure Performance Standards (PMPS) identified by AHCCCS for each measure based on the rates calculated by AHCCCS.

    d. Establish how the Statistically Significant improvement can

be attributable to interventions undertaken by the AdSS, and that the improvement occurred due to the project and interventions, not another unrelated reason.

e. Maintain or increase the improvements in performance for at least one year after the performance improvement is first achieved.

f. Measure and report performance measures, and meet any associated standards mandated by the Division, AHCCCS, or CMS.

g. Achieve the PMPS outlined in the AdSS' contract for each measure using administrative and hybrid rates.

h. Demonstrate sustained and improved efforts throughout the performance cycle when PMPS have been met.

i. Develop an evidence-based Corrective Action Plan (CAP) for each measure not meeting the PMPS, including interventions to meet the specific needs of Division Members to bring performance up to the minimum standards required by AHCCCS while adhering to AMPM Policy 920, Attachment B.

j. Ensure each CAP includes a list of activities or strategies that the AdSS are using to allocate increased administrative resources to improve rates for a specific measure or service area.

k. Demonstrate and sustain improvement towards meeting PMPS.

5. The Division may take administrative action for PMPS that do not show Statistically Significant improvement in Official Rates.

6. The Division may take administrative action for Statistically Significant declines of rates or any rate that does not meet the PMPS or a rate that has a significant impact to the aggregate rate for the State.

7. The Division shall require the AdSS to report the status of any discrepancies identified in encounters submitted to and received by the Division for purposes of performance measure monitoring.

8. The Division is responsible for:

a. Monitoring encounter submissions by the Division's

subcontractors;

b. Demonstrating improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS;

c. Complying with national performance measures and levels that may be identified and developed by CMS in consultation with AHCCCS; and

d. Ensuring the CAPs are approved by AHCCCS prior to implementation.

9. The Division shall internally measure and report to AHCCCS the Division's performance on contractually mandated performance measures using a standardized methodology established or adopted by AHCCCS.

10. The Division shall use the results of the AHCCCS contractual performance measures in evaluating the Division's QM/PI program.

C. PERFORMANCE MEASURE ANALYSIS

1. The Division shall conduct data analysis of performance measure

rates to improve the quality of care provided to Members, identify opportunities for improvement, and implement targeted interventions.

2. The Division shall evaluate performance for aggregate and subpopulations, inclusive of Members with special health care needs, as well as any other focus areas identified by AHCCCS.

3. The Division shall utilize proven quality improvement tools when conducting root-cause analysis and problem-solving activities.

4. The Division shall identify and implement targeted interventions to address any noted disparities identified as part of the Division's data analysis efforts.

5. The Division shall conduct Plan-Do-Study-Act (PDSA) Cycles to Evaluate the effectiveness of interventions, revise interventions as needed, and conduct repeat PDSA Cycles until improvement is achieved.

D. INTER-RATER RELIABILITY

1. The Division shall use the following process to collect data used to measure performance:

a. Assign qualified personnel to collect data,

b. Ensure Inter-Rater Reliability if more than one person is collecting and entering data, and

c. Submit specific documentation to verify that indicator criteria were met in accordance with AHCCCS instruction.

2. The Division shall ensure that data collected from multiple individuals is consistent and comparable through an implemented Inter-Rater Reliability process as specified in Medical Policy 960.

3. If requested by AHCCCS, the Division shall provide evidence of implementation of the Inter-Rater Reliability process and the associated Monitoring.

E. PERFORMANCE METRIC AND MEASURE REPORTING

1. The Division's QM/PI Committee shall review performance measure analytics and recommendations from subcommittees to improve the quality of the care provided to Members, identify opportunities for improvement, and implement targeted interventions on a quarterly basis.

2. The Division shall combine performance measure outcomes from the AdSS and submit those results to AHCCCS as specified in the AHCCCS contract.

3. The Division shall report on LTSS specific performance measures and outcomes managed by the Division, through qualified vendors, as well as the LTSS specific performance measures and outcomes managed by the AdSS.

4. The Division shall report the Division's QM/PI program performance to the AHCCCS Quality Improvement Team, as specified in the AHCCCS contract, utilizing the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template found on the AHCCCS website.

F. AdSS OVERSIGHT

1. The Division shall use the following methods to ensure the AdSS are in compliance with AdSS Medical Policy 970 and associated policies:

   a. Conduct annual operational reviews for compliance;

   b. Analyze deliverable reports and other data as required;

c. Conduct oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any performance measures or other quality of care concerns; and

d. Review data submitted by the AdSS demonstrating ongoing compliance Monitoring of the AdSS' network and provider agencies through Behavioral Health Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 10:18 PDT)
Anthony Dekker, D.O.

980 PERFORMANCE IMPROVEMENT PROJECTS

REVISION DATE: 9/6/2023, 12/7/2022, 9/15/2021, 07/29/2020, 11/17/2017, 05/13/2016
EFFECTIVE DATE: May 13, 2021
REFERENCES: 42 CFR 438.320, 42 CFR 438.330, AMPM 980 - Attachment A

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) regarding the management and implementation of AHCCCS-mandated and Division self-selected Performance Improvement Projects (PIPs) within the Quality Management/ Performance Improvement (QM/PI) Program and its responsibilities to monitor, provide oversight and ongoing evaluation of the Administrative Services Subcontractors' (AdSS) performance.

DEFINITIONS

1. "Baseline Data" means data collected at the beginning of a PIP that is used as a starting point for measurement and the basis for comparison with subsequent remeasurement(s) in demonstrating significant and sustained improvement.
2. "Benchmark" means the process of comparing a practice's performance with an external standard to motivate engagement

in Quality improvement efforts and understand where performance falls in comparison to others. Benchmarks may be generated from similar organizations, Quality collaboratives, and authoritative bodies.

3. "Grievance" means a Member's expression of dissatisfaction with any matter, other than an adverse benefit determination.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive Outcome.
6. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
7. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
8. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].

9. "Performance Improvement Project" or "PIP" means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery.
10. "Plan Do Study Act Cycle" or "PDSA Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, implementing it, observing the results, and analyzing results for Outcomes on the interventions. When these steps are conducted over a relatively short time period, i.e., over days, weeks, or months, the approach is known as Rapid Cycle Improvement.
11. "Plan Do Study Act Method" or "PDSA Method" means a four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA Cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

12. "Quality" as specified in 42 CFR 438.320, pertains to external Quality review, means the degree to which an MCO increases the likelihood of desired Outcomes of its Members through:
    a. Its structural and operational characteristics.
    b. The provision of services that are consistent with current professional, evidence-based knowledge.
    c. Interventions for performance improvement.
13. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.
14. "Validation" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

POLICY

A. PIP REQUIREMENTS

1. The Division shall participate in AHCCCS-mandated and Division self-selected PIPs.

2. The Division shall select, with AHCCCS approval, additional PIPs based on self-identified opportunities for improvement, as supported by a root cause analysis, external and internal data, surveillance of trends and other information available to the Division.
3. The Division shall consider all populations and services covered when developing Quality assessments and PIPs.
4. The Division shall participate in performance measures and PIPs that are mandated by the Centers for Medicare and Medicaid Services (CMS).
5. The Division shall develop, design and implement PIPs to improve systemic and Member-focused Outcomes and demonstrate sustainable improvement in clinical care and non-clinical services, through:
    a. Measurement of performance using objective Quality indicators.
    b. Implementation of interventions to achieve improvement in access to and Quality of care.

c. Evaluation of the effectiveness of the interventions based on indicators collected as part of the PIP

d. Planning and initiation of activities for increasing or sustaining improvement (42 CFR 438.330(d)(2)).

B. PIPS DESIGN

1. The Division shall conduct PIPs that focus on either clinical or non-clinical areas.

   a. The Division may, when determined appropriate by the Division, include the following topics when selecting a clinical topic:

      i. Primary, secondary, or tertiary prevention of acute conditions;

      ii. Primary, secondary, or tertiary prevention of chronic conditions;

      iii. Primary, secondary, or tertiary prevention of behavioral health conditions;

      iv. Care of acute conditions;

      v. Care of chronic conditions;

      vi. Care of behavioral health conditions; and

vii. Continuity and coordination of care.

b. The Division may, when determined appropriate by the Division, include the following topics when selecting a non-clinical topic:

i. Availability, accessibility, and adequacy of Contractor's service delivery system;
ii. Cultural competency of services;
iii. Interpersonal aspects of care; and
iv. Appeals, Grievances, and other complaints.

2. The Division shall identify and implement clinical and non-clinical focused PIPs that are meaningful to the populations served and based on self-identified opportunities for improvement.

3. The Division shall support these PIPs by using:

a. Root cause analyses;

b. External and internal data;

c. Surveillance of trends; or

d. Other information available to the Division.

4. The Division shall adhere to the protocol in 42 CFR 438.330 when developing PIPs.

5. The Division shall adhere to and align with the protocol specified in AMPM Policy 980 – Attachment A, Protocol for Conducting Performance Improvement Projects, when selecting, designing, developing, and implementing self-selected PIPs.

6. The Division shall use the PDSA Method to test changes or interventions quickly and refine them, as necessary.

7. The Division shall utilize several PDSA Cycles within the PIP lifespan.

8. The Division shall include the following steps in the PDSA Cycle:

    a. Plan the changes or interventions, including a plan for collecting data.

    b. State the Objectives of the interventions.

    c. Try out the interventions and document any problems or unexpected results.

    d. Analyze the data and study the results.

e. Compare the data to predictions and summarize what was learned.

f. Refine the changes or interventions, based on what was learned, and prepare a plan for retesting the interventions.

g. Continue the cycle as new data becomes available until sustainable improvement is achieved.

9. The Division shall include all PDSA Cycles conducted as part of the PIP within the Division's PIP Report submissions.

C. PIP TIMEFRAMES

1. For AHCCCS-Mandated PIPs, the Division shall do the following:
   a. Initiate mandated PIPs on a date that corresponds with the calendar year established by AHCCCS.
   b. Collect and analyze Baseline Data at the beginning of the PIP.
   c. Implement innovative and-evidence-based interventions to improve performance based on an evaluation of barriers

and root cause analysis during the Intervention years or annual measurements.

d. Consider any unique factors such as:

i. The Division's membership,

ii. The provider network, and

iii. The geographic area(s) served.

e. Report at the intervals indicated within the associated PIP methodologies in cases where AHCCCS elects to implement Rapid Cycle PIPs.

f. Continue to participate in the PIP until the Division demonstrates significant and sustained improvement, as outlined in Section E, or as directed by AHCCCS.

2. For Division Self-Selected PIPs, the Division shall do the following:

a. Implement Rapid Cycle PIPs where applicable and appropriate, and

b. Continue to participate in the PIP until the Division demonstrates significant and sustained improvement, as outlined in Section E, or as approved by AHCCCS when

significant and sustained improvement has not been demonstrated.

D. DATA COLLECTION METHODOLOGY

1. The Division shall align their data collection Methodology, including project indicators, procedures, and timelines with the guidance and direction provided for all AHCCCS-mandated PIPs.
2. The Division shall evaluate their performance on the selected PIP indicators based on systematic, ongoing collection and analysis of accurate, valid, and reliable data as collected and reported by AHCCCS or as validated by the AHCCCS External Quality Review Organization (EQRO).
3. The Division shall ensure collected data are accurate, valid, and reliable through internal processes for self-selected PIPs that are not based on standardized performance measures.

E. INTER-RATER RELIABILITY

1. For PIPs that are not based on standardized performance measures as well as performance measures not included within AHCCCS Contract, the Division shall:

a. Submit specific documentation to verify that indicator criteria were met in accordance with AHCCCS instruction,

b. Have qualified personnel collect data,

c. Ensure inter-rater reliability if more than one person is collecting and entering data.

2. The Division shall ensure that data collected from multiple parties or individuals for PIP indicators is consistent and comparable through an implemented inter-rater reliability process.

3. The Division shall contain in their documented inter-rater reliability process:

a. A detailed description of the Division's Methodology for conducting inter-rater reliability including:

i. Initial training and retraining, if applicable;

ii. Oversight;

iii. Validation of data collection; and

iv. Other activities deemed applicable.

b. The required minimum score that each individual shall obtain in order to continue participation in the data collection and reporting process;

c. A mechanism for evaluating individual accuracy scores and any subsequent accuracy scores, if applicable; and

d. The actions taken should an individual not meet the established accuracy score.

4. The Division shall monitor and track the inter-rater reliability accuracy scores and associated follow up activities.

5. The Division shall provide evidence to AHCCCS of implementation of the inter-rater reliability process as well as the associated Monitoring upon request.

F. MEASUREMENT OF SIGNIFICANT DEMONSTRABLE IMPROVEMENT

1. The Division shall implement interventions to achieve and sustain Statistically Significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator.

2. The Division shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured.
3. The Division shall provide evidence to AHCCCS of improvement in repeated measurements of the PIP indicators specified for each active PIP.
4. The Division shall demonstrate significant improvement when the improvement in the PIP indicator rate(s) from one measurement year to the next measurement year is Statistically Significant.
5. The Division shall demonstrate sustained improvement when it:
    a. Establishes how the significant improvement can be attributable to interventions implemented by the Division; and
    b. Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance is first achieved.

G. PIPS REPORTING REQUIREMENTS

1. The Division shall refer to the AHCCCS Quality Management/Performance Improvement (QM/PI) Reporting

Templates & Checklists section of the AHCCCS website to locate the associated tools the Division shall utilize, as outlined in this section, when preparing and submitting the required deliverables.

2. The Division shall include baseline and annual remeasurements, inclusive of rates and results used as the basis for analysis, both quantitative and qualitative, and the selection or modification of interventions, within the Division's PIP report submissions.
3. The Division shall submit reports that contain population and line of business-specific data reflective of the Division's performance during the current and previous reporting periods in alignment with the associated PIP timeline.
4. The Division shall ensure the inclusion of subpopulation data and disparity analyses within its reporting, with the identification of targeted interventions to be implemented specific to findings, in alignment with the AHCCCS PIP Report Template and Attachment instructions.
5. For AHCCCS-mandated PIPs, the Division shall do the following:

a. Submit PIP reports for all AHCCCS-mandated PIPs, as specified in the AHCCCS contract.

b. Utilize the AHCCCS PIP Report Template and Attachment that is applicable to the population/line of business being reported.

c. Report rates and results, reflective of combined Title XIX and Title XXI populations, as applicable to the population/line of business.

d. Indicate if the interventions are applicable to Title XIX, Title XXI, or both populations.

e. Submit a final PIP report, as specified in the AHCCCS contract, following the year in which significant and sustained improvement is demonstrated.

f. Evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official PIP indicator rates, as specified in the AHCCCS contract and the associated AHCCCS PIP Methodology.

g. Utilize its Remeasurement Year two (or subsequent year, if required) PIP report to serve as their final PIP report submission contingent upon the following:

i. The Division has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and

ii. The sections required as part of the final PIP report have been completed.

h. Keep AHCCCS-mandated PIPs open until formal notification of approval for PIP closure from AHCCCS is received.

i. Resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

6. For Division self-selected PIPs, the Division shall do the following:

a. Submit a Contractor Self-Selected PIP Initiation Notification, as specified in the AHCCCS contract.

b. Submit PIP reports for self-selected PIPs, active during the previous calendar year, as specified in the AHCCCS contract.

c. Utilize the AHCCCS PIP Report Template and Attachment, specific to population/line of business.

d. Indicate if measurements or rates and results are reflective of combined Title XIX and Title XXI populations, as applicable to population and line of business.

e. Indicate if the interventions are applicable to the Title XIX, Title XXI, or both populations.

f. Submit a final self-selected PIP report, as specified in the AHCCCS contract, following the year in which significant and sustained improvement is demonstrated.

g. Evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official performance measure rates, as specified in the AHCCCS contract.

h. Evaluate significant and sustained improvement based on the Division's internally collected and validated data for self-selected PIPs that are not based on standardized performance measures and calendar year performance.

i. Utilize its Remeasurement Year two or subsequent year, if required, PIP report to serve as their final PIP report submission to AHCCCS contingent upon the following:
    i. The Division has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and
    ii. The sections required as part of the final PIP report have been completed.

j. The Division shall keep Division self-selected PIPs open until the Division has met criteria related to significant and sustained improvement.

k. The Division shall submit a PIP Closure Request for each PIP they are requesting to close for AHCCCS' review and approval.

l. The Division shall indicate the rationale for closing a PIP in cases where the Division has not met criteria related to significant and sustained improvement to support PIP closure.

m. The Division shall close the PIP when formal notification of approval for PIP closure has been received from AHCCCS.

n. The Division shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:51 PDT)
Anthony Dekker, D.O.

1000 CHAPTER OVERVIEW

REVISION DATES: 09/30/2020, 11/22/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: 9 A.A.C. 34, 42 CFR 438.210

Purpose

The standards and requirements included in this chapter are applicable to the Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS). If requirements of this chapter conflict with specific contract language, the AHCCCS medical contract with the Division will take precedence.

At least annually, the Medical Management Unit will conduct reviews of each AdSS' compliance with the requirements of this chapter. The Division's Medical Management Unit is located within the Division's Health Care Services.

The chapter provides the necessary information to the Division and its AdSS to ensure compliance with federal, state, and AHCCCS requirements to Medical Management activities.

Definitions

The Division's words and phrases in this chapter have the following meanings, unless the context explicitly requires another meaning. Refer to AHCCCS policy for other applicable definitions.

Assess or Evaluate - To study or examine methodically and in detail, typically for purposes of explanation and interpretation.

Authorization Request (Expedited) - Under 42 CFR 438.210, a request for which a provider indicates the Division determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Division must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Authorization Request (Standard) - Under 42 CFR 438.210, a request for which a the Division must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Care Management – A group of activities performed by AdSS to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include day-to-day duties of service delivery.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

Catastrophic Reinsurance - Stop-loss mechanism to provide the Division with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, Medical Policy Manual, and contract are met.

Concurrent Review - Process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. The Division reviewers assess the appropriate use of resources, Level of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.

Continuous Health Care Improvement - Integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

A. Identifying and proactively monitoring high-risk populations,
B. Assisting members and providers in adhering to identified evidence-based guidelines,
C. Promoting care coordination,
D. Increasing and monitoring member self-management, and
E. Optimizing member safety.

Delegated Entity - Qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Division.

Disease Management - An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

A. Identifying and proactively monitoring high-risk populations,
B. Assisting members and providers in adhering to identified evidence-based guidelines,
C. Promoting care coordination,
D. Increasing and monitoring member self-management, and
E. Optimizing member safety.

Goal - Desired result the Division envisions, plans, and commits to achieve within a proposed timeframe.

Grievance - Expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. Grievances do not include "Action(s)" as defined in 9 A.A.C. 34.

Measurable - A gauge to determine definitively whether a goal has been met or progress has been made.

Medical Management - Integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

Methodology - Planned process, steps, activities, or actions taken by the Division to achieve a goal or objective or to progress toward a positive outcome.

Monitoring – Process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results.

Retrospective Review - Process of determining the medical necessity of a treatment/service post-delivery of care.

Utilization Management - Applies to a Division process to evaluate, and approve or deny health care services, procedures, or settings based on medical necessity, appropriateness, efficacy, and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review, and case management.

Monitoring

The Division monitors AHCCCS acute services, for the Division's members, with the following processes:

A. Contracts with acute health plan.

B. Operational Reviews with each Division contracted health plan.

C. Quarterly compliance meetings with each Division contracted health plan.

D. Annual Medical Management plans that include narratives, evaluations, completed work plans from the previous year and new work plans for the current year.

E. Quarterly AHCCCS deliverables (includes EPSDT reports) oversight for Division members.

F. Division contracted health plan quarterly Utilization Management (UM) reports.

G. The Division's Medical Management and Chief Medical Officer or designated Medical Director meetings to discuss data analysis, interventions, and corrective action plans (CAPs). Informal clarification may occur as well as defined CAPs coordinated through the Compliance Units of the Division and the AdSS.

H. Provider manual and member handbook oversight.

I. Health Care Services procedures.

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

REVISION DATES: 07/29/2020, 05/13/2016
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. 438.210(b)(3), 42 C.F.R. 438.406(a)(2)(i), A.R.S. § 36-2907, A.R.S. § 36-2907(B), A.A.C. R9-22-201 et seq, 9 A.A.C. 34, ACOM Policy 438, AHCCCS Contractor Operations Manual (ACOM)

Purpose

This policy outlines the Medical Management administrative requirements.

Definitions

Plan, Do, Study Act (PDSA) Method **-** A four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guide the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

Medical Management Plan

A. The Division of Developmental Disabilities (Division) shall develop a written Medical Management Plan that describes the methodology to meet or exceed the standards and requirements of contract.

B. The Division shall submit the Medical Management Plan, and any subsequent modifications, to the AHCCCS Medical Management for review and approval prior to implementation.

C. At a minimum, the Medical Management Plan shall describe, in detail, the Medical Management program and how program activities assure appropriate management of medical care service delivery for enrolled members. Medical Management Plan components shall include:

1. A description of the Division's administrative structure for oversight of its Medical Management program, including the role and responsibilities of:

    a. The governing or policy-making body,

    b. The Medical Management Committee,

    c. The Division Executive Management, and

    d. Medical Management program staff.

2. An organizational chart that delineates the reporting channels for Medical Management activities and the relationship to the Chief Medical Officer (unless delegated to an associate Medical Director) and Executive Management.

3. Documentation that the governing or policy-making body has reviewed and approved the Medical Management Plan.

4. Documentation that appropriately qualified, trained, and experienced personnel are employed to effectively carry out Medical Management program functions.

5. The Division's specific Medical Management goals and measurable objectives as required by AHCCCS policy.

6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:

   a. Medical Management Utilization Data Analysis and Data Management

   b. Concurrent Review

   c. Discharge Planning

   d. Prior Authorization

   e. Inter-Rater Reliability

   f. Retrospective Review

   g. Clinical Practice Guidelines

   h. New Medical Technologies and New Uses of Existing Technologies

   i. Case Management/Care Coordination

   j. Disease/Chronic Care Management

   k. Drug Utilization Review

7. The Division's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AHCCCS policy.

8. A description of how delegated activities are integrated into the overall Medical Management program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS policy.

9. Documentation of input into the medical coverage policies from the Division or providers and members.

10. A summary of the changes made to the Division's list of services requiring prior authorization and the rationale for those changes.

Medical Management Work Plan

The Division is responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the Medical Management program requirements outlined in AHCCCS policy. The work plan shall:

A. Be submitted in an acceptable format or in the template provided by the Medical Management Unit.

B. Supports the Medical Management Plan goals and objectives.

C. Include goals that are quantifiable and reasonably attainable.

D. Includes specific actions for improvement.

E. Incorporates a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AHCCCS policy for details related to PDSA methodologies.

Medical Management Evaluation

A. An annual narrative evaluation of the effectiveness of the previous year's Medical Management strategies and activities shall be submitted to AHCCCS Medical Management after being reviewed and approved by the Division's governing or policy-making body. The narrative summary of the previous year's work plan shall include but is not limited to:

1. A summary of the Medical Management activities performed throughout the year with:

    a. Title/name of each activity,

    b. Desired goal and/or objective(s) related to each activity,

    c. Staff positions involved in the activities,

    d. Trends identified and the resulting actions implemented for improvement,

    e. Rationale for actions taken or changes made, and

    f. Statement describing whether the goals/objectives were met.

2. Review, evaluation, and approval by the Medical Management Committee of any changes to the Medical Management Plan.

3. Necessary follow-up with targeted timelines for revisions made to the Medical Management Plan.

B. The Medical Management Plan and Medical Management Evaluation may be combined or written separately, as long as required components are addressed and easily located.

C. Refer to AHCCCS policy for reporting requirements and timelines.

Medical Management Administrative Oversight

A. The Division shall ensure ongoing communication and collaboration between the Division Medical Management program and the other functional areas of the Division (e.g., quality management, member, and provider services).

B. The Division shall have an identifiable and structured Medical Management Committee that is responsible for Medical Management functions and responsibilities, or if the Medical Management Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that Medical Management issues and topics are presented, discussed and acted upon.

C. At a minimum, the membership includes:

1. The Chief Medical Officer or appointed designee as the chairperson of the Medical Management Committee,

2. The Medical Management Manager,

3. Representation from the functional areas within the Division, and

4. Representation of contracted or affiliated providers.

D. The Chief Medical Officer, unless delegated to an associate Medical Director, as chairperson for the Medical Management Committee, or his/her designee, is responsible for the implementation of the Medical Management Plan and has substantial involvement in the assessment and improvement of Medical Management activities.

E. The Medical Management Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or Medical Management Committee sign-in sheets with requirements noted).

F. The frequency of Medical Management Committee meetings is sufficient to demonstrate that the Medical Management Committee monitors all findings and required actions. At a minimum, the Medical Management Committee meets quarterly.

G. Medical Management Committee meeting minutes include the data reported to the Medical Management Committee, and analysis and recommendations made by the Medical Management Committee. Data, including utilization data, may be attached to the Medical Management Committee meeting minutes as separate documents if the documents are noted in the Medical Management Committee meeting minutes.

Recommendations made by the Medical Management Committee shall be discussed at subsequent Medical Management Committee meetings. The Medical Management Committee shall review the Medical Management program objectives and policies annually and updates them as necessary to ensure:

1. The Medical Management responsibilities are clearly documented for each Medical Management function/activity;

2. Division staff, administrative services sub-contractors (AdSS) and providers are informed of the most current Medical Management requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community;

3. The providers are informed of information related to their performance (e.g., provider profiling data); and

4. The Medical Management policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS Medical Management Unit.

H. The Medical Management shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities.

I. Staff qualifications for education, experience and training are developed for each Medical Management position.

J. The grievance process shall be part of the new hire and annual staff training. including, but not limited to:

1. What constitutes a grievance,

2. How to report a grievance, and

3. The role of the Quality Management staff in grievance resolution.

K. A current organizational chart is maintained to show reporting channels and responsibilities for the Medical Management program.

L. The Division shall maintain records that document Medical Management activities and shall make the information available to AHCCCS Medical Management Unit upon request. The required documentation includes, but is not limited to:

1. Policies and procedures;

2. Reports;

3. Practice guidelines;

4. Standards for authorization decisions;

5. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization);

6. Meeting minutes including analyses, conclusions, and actions required with completion dates;

7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the Medical Management program such as inter-rater-reliability; and

8. Other information and data deemed appropriate to support changes made to the scope of the Medical Management Plan.

M. The Division shall have written policies and procedures pertaining to:

1. Verification that information/data received from providers is accurate, timely, and complete;

2. Review of reported data for accuracy, completeness, logic, and consistency, (review and evaluation processes shall be clearly documented);

3. Security and confidentiality of all member and provider information protected by federal and state law;

4. Informing appropriate parties of the Medical Management requirements and updates, utilization data reports, and profiling results;

5. Identification of provider trends and subsequent necessary corrective action;

6. Quarterly evaluations and trending of subcontracted health plan internal appeal overturn rates;

7. Quarterly evaluations of the timeliness of service request decisions; and

8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

N. The Division shall have processes that ensure:

1. Per 42 C.F.R. 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, render decisions to:

a. Deny an authorization request based on medical necessity;

b. Authorize a request in an amount, duration, or scope that is less than requested; and

c. Make a decision involving excluded or limited services under A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in section N4 (below) of this policy.

2. Per 42 C.F.R. 438.406(a)(2)(i), qualified health care professionals, with appropriate clinical expertise in treating the members' condition or disease, and who have not been involved in any previous level of decision making, render decisions regarding:

a. Appeals involving denials based on medical necessity,

b. Grievances regarding denial of expedited resolution of an appeal, and

c. Grievances and appeals involving clinical issues.

3. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and nonskilled services within their scope of practice:

   a. Physician

   b. Podiatrist

   c. Optometrist

   d. Chiropractor

   e. Psychologist

   f. Dentist

   g. Physician assistant

   h. Physical or occupational therapist

   i. Speech-language pathologist

   j. Audiologist

   k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist. certified registered nurse anesthetist and certified nurse midwife)

   l. Licensed social worker

   m. Registered respiratory therapist

   n. Licensed marriage and family therapist

   o. Licensed professional counselor

4. Decision making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

5. In addition to those providers listed above, the following health care professionals have the appropriate clinical expertise to render decisions for non-skilled Home and Community Based Service (HCBS) such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care:

   a. Arizona Long Term Care System (ALTCS) case management staff when the individual is a:

      i. Registered Nurse,

      ii. Licensed Practical Nurse,

iii. Degreed social worker, or

iv. An individual with a bachelor's or master's degree in a related field.

b. Support Coordination ALTCS case management staff with a minimum of two consecutive years of experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities, when the staff individual does not have a degree or a license.

6. Consistent application of standards and clinical criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action is developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%.

7. Prompt notifications to the requesting provider and the member or member's authorized representative or medical power of attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the AHCCCS Contractor Operations Manual (ACOM) and 9 A.A.C. 34.

O. The Division shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its Medical Management program. Data elements shall include but are not limited to:

1. Member demographics;

2. Provider characteristics;

3. Services provided to members; and

4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

P. The Division shall oversee and maintains accountability for all functions or responsibilities that are delegated to other entities. Documentation is kept that demonstrates:

1. A written agreement specifies the delegated activities and reporting responsibilities of the entity to the subcontracted health plan and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

2. The Division shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation per ACOM Policy 438.

3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed annually.

Q. The Division shall ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.

2. Providers are not prohibited from advocating on behalf of members within the service provision process.

1020 UTILIZATION MANAGEMENT

REVISION DATE: 1/25/2023 7/20/2022
EFFECTIVE DATE: August 4, 2021
REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. § 38-211, A.A.C. R9-22-101, A.A.C. R9-28-201, 42 CFR 412.87, 42 CFR Part 437, 42 CFR Part 438, 42 CFR 447.26, 42 CFR 456.125, 42, CFR Part 457, 45 CFR Parts 160 and 164

PURPOSE

This policy outlines the oversight responsibilities of the Division of Developmental Disabilities (Division) to ensure effective treatment services, coordination of care to achieve optimal health outcomes for members served by the Division and identify opportunities for improvement in utilization management. This policy is specifically targeted to the Division's roles and responsibilities related to utilization management and oversight of the AdSS.

DEFINITIONS

1. "Behavioral Health Inpatient Facility (BHIF)" means a health institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

a. Have a limited or reduced ability to meet the individual's basic physical needs;

b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self;

d. Be a danger to others;

e. Be an individual with a persistent or acute disability as specified in A.R.S § 36-501; or

f. Be an individual with a grave disability as specified in A.R.S. § 36-501.

2. "Behavioral Health Residential Facility (BHRF)" means, as specified in A.A.C. R9-10-101, is a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

3. “Care Management” means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

4. “Concurrent Review” means the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care (LOC). Reviewers assess the appropriate use of resources, LOC, and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates for Quality Of Care (QOC).

5. “Denial” means the decision to deny a request made by, or on behalf of, an individual for the authorization and/or payment of a covered service.

6. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
   a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions;
   c. Serious dysfunction of any bodily organ or part as specified in 42 CFR 438.114(a); or
   d. Serious physical harm to another individual (for behavioral health conditions).

7. "Health Care Acquired Condition (HCAC)" means a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions).

8. "Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases as specified in 42 CFR 435.1010.

9. "Institutional Setting" means:

   a. A nursing facility as specified in 42 U.S.C. 1396 r(a);

   b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;

   c. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36- 401;

d. A Behavioral Health Inpatient Facility (BHIF) as specified in A.A.C. R9-10-101;

e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.

10. "Inter-Rater Reliability (IRR)" means the process of monitoring and evaluating qualified healthcare professional staff's level of consistency with decision making and adherence to clinical review criteria and standards.

11. "Other Provider-Preventable Condition (OPPC)" means a condition occurring in the inpatient and outpatient health care setting which the Division and AHCCCS has limited to the following:

a. Surgery on the wrong member,

b. Wrong surgery on a member,

c. Wrong site surgery.

12. "Peer-Reviewed Study" means prior to publication, is a medical study that has been subjected to the review of medical experts who:

a. Have expertise in the subject matter of the study,

b. Evaluate the science and methodology of the study,

c. Are selected by the editorial staff of the publication,

d. Review the study without knowledge of the identity or qualifications of the author, and

e. Are published in the United States.

13. "Prior Authorization (PA)" means a process by which the AdSS authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this policy and as specified in A.A.C. R9-201, and any applicable contract provisions. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

14. "Provider Preventable Condition (PPC)" is a condition that meets the definition of a health care acquired condition or another provider preventable condition as defined by the State of Arizona.

15. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental

disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

16. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

17. "Service Plan (SP)" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

18. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

19. "Subcontracted health plan" means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

20. Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

21. "Telehealth" means healthcare services delivered via asynchronous , remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The Division's Health Care Services (HCS) shall provide oversight and identifies trends, best practices and opportunities for improvement in utilization management through the following:
    a. HCS shall meet with the AdSS' Medical Management (MM) staff on a quarterly basis to review utilization data, trends, performance, and implementation of action plans.
    b. HCS shall review and approve annual AdSS' Medical

Management Program Plan, Work Plan and Evaluation to ensure goals, service quality and outcomes reflect member needs and Division goals.

2. The Division shall work in collaboration with AHCCCS Division of Fee for Service Management (DFSM) to monitor health outcomes of members enrolled in the Tribal Health Program (THP).

3. The Medical Management (MM) Committee shall review utilization data and findings to make recommendations to improve performance and achieve better outcomes. The MM Committee responsibilities include:

   a. The review of validated data provided by the Utilization Management (UM) subcommittee and any other relevant data;

   b. The review of tracking and trending utilization data on an on-going basis to:

      i. Identify under-utilization and/or over-utilization of services;

      ii. Identify opportunities for early intervention,

iii. Mitigate adverse outcomes;

iv. Identify opportunities for improvement and best practices;

v. Review of performance data related to integrated care, such as support coordination activities, access to services, and actions undertaken to resolve barriers to care; and

vi. Review of the utilization data, performance and opportunities for improvement with the AdSS at least quarterly.

4. The UM Subcommittee shall provide a quarterly tracking and trending report, including data provided by the AdSS, to the MM Committee.

5. The UM Subcommittee shall meet at least 10 times per year.

B. CONCURRENT REVIEW

1. The Division shall provide oversight of concurrent review services conducted by the AdSS. The Division shall monitor and review, at least annually, the AdSS' hospital and institutional stays to

ensure that treatment and lengths of stay meet member needs and are provided in accordance with clinical standards of care.

2. The Division shall provide oversight of the AdSS who are required to implement the following:
   a. Pre-certification prior to a planned hospital or institutional admission based on medical necessity and appropriateness of proposed care. After hospital or institutional admission occurs authorization of the continued stay is based on medical necessity established during the concurrent review process.
   b. Clinical documentation includes relevant medical information to be reviewed when making hospital length of stay decisions. Information may include: symptoms, diagnostic test results, diagnoses, and required services. The clinical review shall include the information used for determining the length of stay.
   c. The admission review and subsequent concurrent reviews shall occur within the timeframes and frequency set forth below:

i. Admission reviews shall be conducted within one working day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) as specified in 42 CFR 456.125;

ii. If the hospital or institution does not provide clinical information with the notification of admission, the AdSS shall request the member's medical records pertinent to the admission within one business day;

iii. Continued stay authorizations for hospital and institutional stays shall specify a date by which the next medical review shall be done based on the member's clinical information and criteria guidelines.

3. The Division shall notify providers of the option to request a peer-to-peer discussion with the appropriate AdSS or the AHCCCS DFSM Medical Director when additional information is requested or when the admission or continued stay is denied.

4. HCS shall ensure the concurrent review process is clearly documented and includes the following elements:

a. Medical necessity of admission, level of care and appropriateness of the service setting, criteria used for decision determination;

b. Quality of care, services and setting meeting the member needs;

c. Projected length of stay, based on approved clinical criteria;

d. Continued stay authorization with identification of next review date;

e. Denials or reduction in level of service;

f. Requests for peer-to-peer review and disposition of the request;

g. Proactive discharge planning starting on the day of admission and ongoing throughout the hospital/institutional stay to ensure continuity of care and linkage to required treatment services and supports at discharge;

h. Identification of utilization patterns, such as readmissions, extended length of stays.

5. The Division's support coordinator shall participate proactively in discharge planning for its members admitted to inpatient settings from the day of admission.

6. Support coordination shall manage discharge planning to ensure a safe discharge back to the community and facilitate active engagement from the health plans, health care and behavioral healthcare providers, allied treatment providers, supports and services to meet the comprehensive needs of the member.

7. The support coordinator shall collaborate with AHCCCS DFSM, as appropriate for THP enrolled members.

8. HCS shall review the AdSS' notification of an Institution of Mental Disease (IMD) placement exceeding 15 days and report it to AHCCCS.

9. The AdSS' Medical Management Committee shall annually approve the medical criteria used for concurrent review, which shall be adopted from the national standards. Subsequently it shall be approved by the Division's MM Committee.

10. The Division shall ensure criteria for physical health and behavioral health coverage and medical necessity decisions are clearly documented and based on reasonable medical evidence or the consensus of relevant health care professionals.
11. The Division shall review the AdSS submission of the quarterly Inpatient Hospital Showings Report and sends it to AHCCCS after ensuring the report is signed by the AdSS' Chief Medical Officer attesting that:
    a. A physician has certified to the necessity of inpatient hospital services,
    b. The services were periodically reviewed and evaluated by a physician,
    c. Each admission was reviewed or screened under a utilization review program, and
    d. All hospitalizations of members were reviewed and certified by medical utilization staff.
12. The Division shall collaborate with AHCCCS DFSM to review the Inpatient Hospital Showings Report for Division members enrolled in THP.

C. DISCHARGE PLANNING

1. The Division shall ensure the discharge planning process for members receiving inpatient services has proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member to arrange necessary services and resources for appropriate and timely discharge from a facility.

2. The support coordinator shall proactively engage with the interdisciplinary planning team which includes the hospital/institutional staff, the AdSS UM staff, HCS nurses, health care and behavioral healthcare providers, allied treatment providers, supports and services in discharge planning to meet the comprehensive needs of the member.

3. The Division support coordinator shall engage within the interdisciplinary planning team to support discharge planning from the day of admission and during the inpatient stay and after discharge to ensure all the necessary treatment, services and supports are available to sustain recovery, health, wellness, and well-being upon discharge to the community.

a. If the discharge cannot be affected because of the lack of a resource including return to home or community-based setting, the support coordinator shall identify the needed resource to support discharge from the hospital or institutional setting or resolve member issues and service concerns timely at the lowest level through the identification of care coordination strategies, resources, and clinical consultation.

b. If a covered behavioral health service required after discharge is temporarily unavailable for individuals in an inpatient or residential facility who are discharge-ready, the member may remain in that setting until the service is available. The support coordinator shall work with the Behavioral Health Complex Care Specialist, as needed and/or seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.

4. The support coordinator shall ensure care management, intensive outpatient services, provider support coordination,

and/or peer service are available to the member while waiting for the appropriate covered physical or behavioral health services.

a. The HCS shall compile a census report identifying the number of members who remain in discharge pending status due to the lack of community resources for review by the MM Committee including the barrier, type of resources needed, date of projected discharge and date of discharge.

5. The Division shall ensure discharge planning is performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continues through post-discharge to ensure a timely, effective, safe, and appropriate discharge.

6. Division staff participating in discharge planning shall ensure the member/responsible person, as applicable:

a. Is involved and participates in the discharge planning process;

b. Understands the written discharge plan, instructions, and recommendations provided by the facility;and

c. Is provided with resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

7. The Division shall ensure discharge planning, coordination, and management of care includes, but is not limited to:

a. Follow-up appointment with the PCP and/or specialist within seven business days;

b. Coordination and communication by the Division with inpatient and facility providers for safe and clinically appropriate discharge placement, and community support services;

c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, other entities/contractors, and FFS providers when appropriate;

d. Prescription medications;

e. Medical equipment;

f. Nursing services;

g. End-of-Life Care related services such as Advance Care Planning;

h. Practical supports;

i. Hospice;

j. Therapies;

k. Referral to appropriate community resources;

l. Referral to Disease Management or Care Management (if needed);

m. A post-discharge follow-up call is made by the District nurse to the member/responsible person within three business days of discharge to confirm the member's well-being and progress of the discharge plan;

n. Additional follow-up actions as needed based on the member's needs;

o. Proactive discharge planning when the Division is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The Division's support coordinator and Health Care Services staff shall work in conjunction with the Division's Network Administrator to provide needed support to homeless clinics to identify available providers and assist in obtaining PA to ensure timely delivery of services that are included in the member plan of care.

2. The Division shall not require PA for tribal members utilizing Indian Health Services (IHS)/638 Tribal providers and facilities. Non-IHS/638 providers or facilities rendering covered services shall obtain PA. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

3. The AdSS Medical Management committee shall determine PA criteria and is approved by the Division's Medical Management committee.

4. The Division shall provide oversight of the PA process conducted by the AdSS, including adherence to benefit coverage and timeliness of PA requests.

5. The Division shall provide oversight to ensure that all PA

activities are performed in accordance with AdSS Medical Manual Policy 1020 including, but not limited to:

a. The AdSS shall clearly document its criteria for decisions on coverage and medical necessity for both physical and behavioral health services and be based on reasonable medical evidence or a consensus of relevant health care professionals.

b. The AdSS shall utilize Arizona licensed PA staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the AdSS' medical criteria or make coverage decisions.

c. The AdSS shall implement a system that allows providers to submit PA requests via telephone, fax, and/or electronically through email.

d. Any AdSS network provider who requests authorization for a service shall be notified of the option to request a peer-to-peer discussion with the AdSS Medical Director

when additional information is requested by the Division or when a PA request is denied.

e. The AdSS shall coordinate the discussion with the requesting provider when appropriate.

f. The AdSS shall identify and communicate to providers and members/Responsible Person the services that require and do not require PA and the relevant medical criteria required for authorization decisions.

g. The AdSS shall respond to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Chapter Overview of this Policy Manual, Division Operations Manual policy 414, 42 CFR 457.1230(d), and 42 CFR 438.210(b).

h. The AdSS shall respond as expeditiously as the member's condition requires but no later than 72 hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i). The expedited authorization request shall meet federal standards, because a delay in processing could seriously jeopardize the member's life,

health, or ability to attain, maintain or regain maximum function. If the PA request does not meet the criteria for an expedited request, the requesting provider will be notified and given the opportunity to provide additional clinical information to support the expedited request status. However, if the additional clinical information does not support an expedited request, the PA request will be processed as a standard request within the specified timelines.

h. The AdSS shall communicate information to members/Responsible Person and providers in multiple ways including but not limited to newsletters, the AdSS' websites, the Member Handbooks, and provider manuals.

i. Medical criteria shall be available to members/Responsible Person upon request.

j. The AdSS shall consistently apply medical criteria through inter-rater reliability.

k. The AdSS shall authorize services in a sufficient amount,

duration, and scope to achieve the purpose for which the services are furnished.

l. The AdSS MM Committee and the Division MM Committee shall review and approve any changes to medical criteria and shall be communicated to providers at least 30 business days prior to implementation of the change.

6. The Division shall require PA for the following Medical and Behavioral Health Services:

a. Behavioral Health Residential Facility;

b. Non-emergency Acute Inpatient Admissions;

c. Level I Behavioral Health Inpatient Facility and RTC Admissions;

d. Elective Hospitalizations;

e. Elective Surgeries;

f. Medical Equipment;

g. Medical Supplies;

h. Home Health;

i. Home and Community Based Services;

j. Hospice;

k. Skilled Nursing Facility;

l. Therapies - Rehabilitative/Habilitative;

m. Medical and/or behavioral health services;

n. Nursing facility;

o. Emergency alert system services;

p. Rehabilitative/Habilitative Physical/Occupational Therapy for members twenty-one (21) years of age and older;

q. Behavior Analysis Services;

r. Augmentative and Alternative Communication (AAC) services, supplies, and accessories;

s. Non-Emergency Transportation;

t. Select Medications.

7. The Division shall not require PA for these services:

a. Services performed during a Retroactive Eligibility Period;

b. When Medicare or other commercial insurance coverage is primary;

c. Emergency Medical Hospitalization < 72 hours;

d. Emergency Admission to Behavioral Health Level 1 Inpatient facility, however, notification of the admission to the health plan shall occur within 72 hours;

e. Some Diagnostic procedures, e.g., EKG, MRI, CT Scans, X rays, Labs; check the member's health plan's prior authorization requirements;

f. Dental Care - emergency and non-emergency, check the member's health plan's PA requirements;

g. Eyeglasses for members < 21 years old;

h. Family Planning Services;

i. Physician and/or Specialty Consultations and Office Visits;

j. Behavioral Analysis Assessment;

k. Prenatal Care;

l. Emergency Transportation;

m. Non-Emergency Transportation of less than 100 miles;

n. Emergency room visit.

E. INTER-RATER RELIABILITY

1. The Division shall provide oversight of inter-rater reliability (IRR) done by the AdSS to ensure the consistent application of review criteria in making medical necessity decisions which require PA, concurrent review, and retrospective review. Each AdSS plan is monitored to ensure the following:
    a. Adoption of policy and procedures for conducting inter-rater reliability;
    b. All staff, including medical directors, making medical necessity decisions in PA, concurrent review and retrospective review shall have IRR testing as part of the orientation process and at least annually thereafter;
    c. A process for corrective action shall be developed and implemented for all staff who do not meet the minimum passing compliance standard of 90%.
2. The Division shall conduct IRR testing for the following HCS functions:
    a. Skilled Nursing Services,
    b. Second Level Medical Review.
3. At least annually, the IRR testing results from the AdSS plans,

the District Support Coordination and the Division medical directors are presented to the Medical Management Committee for review and approval.

F. RETROSPECTIVE REVIEW

1. The Division shall oversee the retrospective review of medical necessity of a treatment or service post-delivery of care done by the AdSS plans.

2. The AdSS plans shall be monitored for the following:

   a. Policy and procedure that reflect:

      i. The identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,

      ii. Which services require retrospective review,

      iii. Timeframe(s) established by the AdSS plans for completion of the retrospective review.

3. The Division shall ensure criteria for making medical necessity decisions is clearly documented and based on reasonable

medical evidence or a consensus of relevant health care professionals.

4. The Division shall ensure there is a process for consistent application of review criteria.

5. Guidelines for Provider-Preventable Conditions (PPC), other Provider-Preventable Conditions (OPPC), Health Care Acquired Conditions (HCAC) include:

   a. Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26,

   b. A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

   c. If it is determined that the HCAC or OPPC was a result of an error by a hospital or medical professional, the AdSS

shall conduct a Quality of Care (QOC) investigation and report it in accordance with AdSS Medical Manual Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The Division shall collaborate with the AdSS to ensure the clinical practice guidelines (CPGs) developed by the AdSS meet the individualized needs of the Division members.

2. The AdSS shall develop, adopt and disseminate CPGs for physical and behavioral health services, in accordance with 42 CFR 457.1233(c) and 42 CFR 438.236 that:

   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;

   b. Have considered the individualized needs of the Division's members;

   c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines or developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical

journals published in the United States when national practice guidelines are not available;

d. Are disseminated by the AdSS to all their affected providers and, upon request, to members/Responsible Person and potential members;

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply.

3. The AdSS MM Committee shall evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards every two years.

4. The Division shall review the AdSS' approved CPGs and document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM Committee meeting minutes.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The Division shall collaborate with the AdSS to ensure new medical technologies and new uses of existing technologies to meet the individualized needs of the Division members. The AdSS shall be monitored for the following:

   a. Implementation written procedures for evaluating new technologies and new uses of existing technology that include an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals, and devices;

   b. The procedures shall include both a mechanism for MM Committee review on a quarterly basis and a timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an expedited request shall be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request.

3. The AdSS shall include coverage decisions by Medicare

intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions in its evaluation.

4. The AdSS shall evaluate published or unpublished information sources that may establish that a new medical service or technology represents an advance that substantially improves the diagnosis or treatment of members, as specified in 42 CFR 412.87.

5. The AdSS shall have a process for documenting the coverage determinations and rationale in the MM Committee meeting minutes.

I. DIVISION OVERSIGHT RESPONSIBILITIES

1. The Division MM Committee shall monitor utilization management activities.

2. The MM Committee shall review relevant metrics and reports, and meet quarterly to discuss performance, outliers, and opportunities for improvement for HCS UM activities and AdSS UM activities.

3. HCS shall address the need for improvement of UM activities conducted by the AdSS through quarterly meetings with the AdSS and through the UM Subcommittee as well as the Division's Operational Review.

J. SUPPLEMENTAL INFORMATION

1. The Division is responsible for the oversight of the AdSS' administration of utilization management activities for all services provided to members of the Division.
2. AHCCCS DFSM is responsible for the administration of utilization management functions for acute physical and behavioral health services for Division members enrolled in the Tribal Health Program.
3. The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post discharge services, reduce unnecessary hospital and institutional stays, ensure discharge needs are met, and decrease readmissions.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:46 MST)
Anthony Dekker, D.O.

1021 CARE MANAGEMENT

REVISION DATE: 11/8/2023
EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. § 13-3994; A.R.S. § 31-501; A.R.S. §§ 36-551; A.R.S. § 38-211; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi); 42 CFR 438.208(b)(2)(ii) and (iii); 42 CFR 438.208(b)(2)(iv); 42 CFR 457.1220; 42 CFR 457.1230(c); 45 CFR Part 160 and 164; AMPM 310-HH; AMPM 520; AMPM 570; AMPM 580; AMPM 940; AMPM 1010; AMPM 1021; AMPM 1620; ACOM 438.

PURPOSE

This policy sets forth roles and responsibilities of the Division of Developmental Disabilities (Division)for provision of Care Management services and collaboration with Support Coordination to improve health outcomes for Tribal Health Program (THP) Members who have physical or behavioral health needs or risks that require immediate Division intervention. This policy provides information on the Division's monitoring and oversight of the Administrative Services Subcontractors (AdSS) Care Management and High Needs/High Cost (HNHC) programs. The policy also provides details of the Divisions responsibilities for the High Needs/High Cost program.

DEFINITIONS

1. "Advance Care Planning" means a part of the End-of-Life Care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
   a. Educate the member about their illness and the health care options that are available to them.
   b. Share the member's wishes with family, friends, and his or her physicians.
   c. Develop a written care plan that identifies the member's choices for treatment.
2. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.
3. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help

achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

4. "Care Manager" means someone who provides Care Management services.

5. "Division Tribal Team" means for the purpose of this policy, the Tribal Liaison (Tribal Social Service referrals), Tribal Health Coordinator (general healthcare navigation inquires) and the Tribal RN Liaison (referrals to IHS 638 facilities programs), depending on the service need.

6. "End-of-Life Care" means a concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.

7. "Informal Supports" means non-billable services provided to a member by a family member, friend, or volunteer to assist or

perform functions such as:

a. Housekeeping,

b. Personal care,

c. Food preparation,

d. Shopping,

e. Pet care, or

f. Non-medical comfort measures.

8. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

10. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the Services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

11. "Planning Team" means a group of people including the Member;

the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member; Responsible Person; or the Department.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

13. "Social Determinants of Health" or "SDOH" means the social, environmental, and economic factors that can influence health status and have an impact on health outcomes.

14. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

15. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

16. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The Division shall have in place a Care Management process with the primary purpose of coordinating care and assisting in accessing resources for ALTCS eligible Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The Division shall ensure the AdSS provides Care Management for members enrolled with the AdSS.

3. The Division shall provide Care Management for members

enrolled with the Tribal Health Program.

4. The Division shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, or provider.

5. The Division shall provide Care Management that is designed to be short-term and time-limited in nature.

6. The Division shall require the following Care Management services:
    a. Assistance in making and keeping needed physical or behavioral health appointments;
    b. Following up and explaining hospital discharge instructions;
    c. Health coaching and referrals related to the Member's immediate needs;
    d. Primary Care Provider (PCP) reconnection; and
    e. Offering other resources or materials related to wellness, lifestyle, and prevention.

7. The Division shall provide care coordination to ensure Members

receive the necessary services to prevent or reduce an adverse health outcome.

8. The Division shall ensure that clinical resources and assessment tools utilized are evidenced-based.
9. Care Managers shall establish a process to ensure coordination of Member physical and behavioral health care needs across the continuum, based on early identification of health risk factors or Special Health Care Needs (SHCN) consistent with the Planning Document.
10. The Division shall ensure the coordination ensures provision of physical and behavioral services in any setting that meets the Member's needs in the most cost-effective manner available.
11. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and coordinating care.
12. The Division shall implement a Care Management system that automatically documents the staff member's name and ID and

the date and time the action or contact with the member occurred.

13. The Division shall implement a Care Management system that provides automatic prompts and reminders to follow-up with the member as specified in the member's care plan.

14. The Division shall provide Care Management as an administrative function.

15. The Division shall obtain approval by the Arizona Health Care Cost Containment System (AHCCCS) prior to delegating a portion of the Care Management functions to another entity.

16. The Division shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the TRBHA case manager.

17. Care Managers shall work closely with case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

18. The Division shall identify and refer members that meet criteria

for Care Management services, including:

a. Frequent use of the Emergency Department instead of seeing providers for ongoing issues (4 or more occurrences within the past 6 months);

b. Multiple physical or behavioral health hospitalizations (3 or more inpatient or readmissions within the past 6 months);

c. Discharged from an inpatient or skilled facility and requires coordination of post-acute services;

d. Missed 3 or more physical or behavioral health appointments within the past 3 months;

e. Having difficulty obtaining medical benefits or referrals ordered by providers;

f. Diagnosed with heart failure, diabetes, asthma, chronic obstructive pulmonary disease, or depression and requires assistance with management of the condition;

g. In the process of receiving a transplant or up to one year post-transplant;

h. Diagnosed with Human Immunodeficiency Virus (HIV);

i. Pregnant;

j. Diagnosed with a behavioral health disorder, the condition is not stable and requires assistance with management of the condition;

k. Needs exclusive provider restriction for overutilization of drugs with abuse potential;

l. Needs referral to or is currently receiving Medication Assisted Treatment (MAT) for opioid use;

m. Has Social Determinants Of Health (SDOH) needs that are impacting member's ability to obtain the appropriate care (e.g., basic needs not being met, safety issues in home environment, etc.);

n. Survivor of sex trafficking;

o. Recently been incarcerated or is transitioning out of jail or prison within the next 30 days;

p. Needs out of state services;

q. Requires assistance with Tribal Nations or providers;

r. Is a child with one or more of the following:

i. Newborn with neonatal abstinence syndrome or maternal drug exposure,

ii. Child and Adolescent Level of Care Utilization System (CALOCUS) level 4 or higher,

iii. Serious emotional disturbance,

iv. Recently removed from their home and placed in foster care.

s. Have multiple complaints regarding services or the Arizona Health Care Cost Containment System (AHCCCS) Program. This includes members who do not otherwise meet the Division criteria for Care Management as well as members who contact governmental entities for assistance, including AHCCCS.

19. The Division shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMRs), health services programs within the organization, or other advanced data sources to develop the selection criteria.

20. The Division shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. DIVISION CARE MANAGEMENT RESPONSIBILITIES FOR THP MEMBERS

1. Care Managers shall comprehensively assess the Member and develop and implement a care plan that has the following:
    a. Initial assessment of Members:
        i. Health status;
        ii. Physical and behavioral health history, including medications and cognitive function;
        iii. Activities of daily living; and
        iv. SDOH.

b. Life planning activities, including wills, living wills, advance directives, health care powers of attorney, End-of-Life Care and Advance Care Planning.

c. Evaluation of:

   i. Cultural and linguistic needs and preferences;

   ii. Visual and hearing needs and preferences;

   iii. Caregiver resources; and

   iv. Availability of services, including community resources.

d. Development of a Care Management plan, including self-management tools, prioritized goals that consider Member and caregiver preferences and desired level of involvement;

e. Identification of barriers;

f. Facilitation of referrals and a follow-up process to determine if Members act on referrals made;

g. Development of a schedule for follow-up and

communication with the Member;

h. A process and timeframe for monitoring the effectiveness of the Care Management plan.

2. Care Managers shall work with the Support Coordinator, the provider case manager, Division Tribal Team, the Primary Care Physician (PCP) or specialists to coordinate and address Member needs within 30 days after the member has been determined eligible to receive Care Management.
3. Care Managers shall continuously document interventions and changes in the care plan.

C. DIVISION RESPONSIBILITIES

1. The Division shall ensure integration of services and continuity of care by:
   a. Ensuring that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements including those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR

438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);

b. Allowing Member choice in selecting a PCP, TRBHA or a behavioral health provider who is formally designated as having primary responsibility for coordinating the member's overall health care.

c. Ensuring access to care that is appropriate to their individual needs as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

d. Ensuring each Member receiving care coordination has an individual or entity that is formally designated as primarily responsible for coordinating services for the Member, such as the Support Coordinator, the provider case manager, or TRBHA case manager;

e. Ensuring the Care Manager provides the Responsible Person with information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

f. Specifying under what circumstances services are coordinated by the Division, including the methods for coordination and specific documentation of these processes;

g. Coordinating the services for Members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i);

h. Coordinating covered services with the services the Member receives from another entity or FFS provider as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(ii) and (iii);

i. Coordinating covered services with community and Informal Supports that are generally available through another entity or FFS provider in the Division's service area, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(iv);

j. Ensuring Members receive End-of-Life Care and Advance Care Planning;

k. Ensuring Care Managers establish timely and confidential communication of data and clinical information among providers that includes:

   i. The coordination of Member care among the PCP, AdSS, and tribal entities;

   ii. Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division or FFS provider and Tribal provider to include TRBHA when the PCP becomes aware of the Division, or TRBHA involvement in care.

l. Ensuring that the PCP is providing pertinent diagnoses and changes in condition to the Division:

   i. No later than 30 days from change in medication or diagnosis, or

   ii. No later than 7 days of hospitalization.

m. Facilitating this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs;

n. Ensuring Care Managers provide consultation to a Member's inpatient and outpatient treatment team and directly engages the Responsible Person as part of Division Care Management;

o. Ensuring individuals admitted to a hospital who are identified as in need of behavioral health services, are responded to as specified below:

   i. Upon notification of an individual who is not currently receiving behavioral health services, the Division shall ensure a referral is made to a provider agency within 24 hours.

p. Ensuring that provider agencies attempt to initiate services with the individual within 24 hours of referral and that the provider agency schedules additional appointments and services with the individual prior to discharge from the

hospital;

q. Ensuring coordination, transition, and discharge planning activities are completed consistent with providers orders to ensure cost effectiveness and quality of care consistent with providers orders to ensure cost effectiveness and quality of care for Members already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the Division's provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensuring access to appropriate services such as Medication Assisted Treatment (MAT) and peer support services;

2. The Division shall develop policies and implement procedures for Members with SHCN, as specified in the contract with AHCCCS and AMPM Policy 520, including:

a. Identifying Members with SHCN;

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each Member;

c. Ensuring adequate care coordination among providers or TRBHAs;

d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the Member's condition and identified needs (e.g., a standing referral or an approved number of visits); and

e. Additional care coordination activities based on the needs of the Member.

3. The Division shall implement measures to ensure that the Responsible Person is involved in Care Management:

a. Is informed of particular health care conditions that require follow-up;

b. Receives, as appropriate, training in self-care and other measures they may take to promote their own health; and

c. Is informed of their responsibility to comply with prescribed treatments or regimens.

4. The Division Care Management shall focus on achieving Member wellness and autonomy through:
   a. Advocacy,
   b. Communication,
   c. Education,
   d. Identification of service resources, and
   e. Service facilitation.

5. Care Managers shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS providers, and facilities throughout the continuum of services.

6. Care Managers shall ensure that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the Member and the Division.

7. The Division shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS Program. This includes Members who do not otherwise meet the Division criteria for Care Management, as well as Members who contact governmental entities for assistance,

including AHCCCS.

8. The Division shall report its monitoring of Members awaiting admission and those Members who are discharge-ready from Arizona State Hospital (ASH) utilizing the Arizona State Hospital Admission and Discharge Deliverable Template.

9. The Division shall demonstrate proactive care coordination efforts for all Members awaiting admission to, or discharge from ASH.

10. The Division's Health Care Services Complex Care team shall coordinate with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge.

11. The Division shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The Division shall submit the following, in the case that a THP Member has been awaiting admission to, or discharge from ASH

for an excess of 90 days:

a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and

b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.

13. The Division shall provide the AMPM 1021 Attachments A, B and E as specified in the contract with AHCCCS.

14. The Division shall arrange ongoing medically necessary nursing services consistent with providers orders to ensure cost effectiveness and quality of care in the event that a Member's mental status renders themself incapable or unwilling to manage their medical condition and the Member has a skilled medical need.

15. The Division shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

16. The Division shall implement interventions to educate the Responsible Person on appropriate use of ED and divert Members to the right care in the appropriate place of service.

17. The Division shall ensure Care Management interventions to educate Responsible Person include:
    a. Outreach phone calls or visits,
    b. Educational letters,
    c. Behavioral health referrals,
    d. HNHC program referrals,
    e. Disease or chronic Care Management referrals,
    f. Exclusive pharmacy referrals, or
    g. SDOH resources.

18. HCS shall submit AMPM Attachment 1021-A as specified in the contract with AHCCCS, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

19. The Division shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

20. The Division shall coordinate care with the ED and the Member's treatment team to discharge the Member to the most appropriate placement or wrap-around services immediately upon notification that a Member who requires behavioral health placement or wrap-around services is in the ED.

21. The Division's Chief Medical Officer shall be involved when THP members experience a delay in discharge from institutional settings or the ED.

22. The Division shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with AHCCCS.

23. The Division shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the Medical Management (MM) Program workplan.

24. The Division shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.

25. The Division shall report the plan specifying the strategies for improving care coordination and the outcome measurement in the annual MM Program Plan, and submitted as specified in the contract with AHCCCS, utilizing AMPM Policy 1010 Attachment A and Attachment B.

26. The Division Tribal Team shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to eligible American Indian and Alaskan Native Members.

27. The Division Tribal Team shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.

28. The Division's Behavioral Health Complex Care Specialist and Support Coordinator shall coordinate with the AdSS to provide assistance with care coordination for Members who are awaiting placement into ASH by communicating with the Responsible Person, Support Coordinator, facilities, providers, and ASH.

D. DIVISION MONITORING AND OVERSIGHT

1. The Division shall ensure the AdSS provides the following, in the case that a Member has been awaiting admission to, or discharge from ASH for an excess of 90 days:
   a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and
   b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.
2. The Division shall review the deliverables received from the AdSS and submit the following reports to AHCCCS:
   a. Barrier analysis report,
   b. Status report for each member awaiting admission or discharge.
3. The Division shall ensure the AdSS provides the AMPM 1021 Attachments A, B and E as specified in the contract.
4. The Division shall review AMPM 1021 Attachments A, B and E

provided by the AdSS prior to sending to AHCCCS.

5. The Division HCS shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and recommendations to refine processes to optimize results.

6. The Division HCS shall meet with the AdSS quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over and under-utilization, outliers, and opportunities for performance improvement.

7. The Division shall ensure the AdSS submit an overview of the Medical Management (MM) program plan checklist AMPM 1010 Attachment A and a MM workplan, AMPM 1010 Attachment B.

1. The Division shall monitor the overall performance of Care Management services including:
   a. Tracking and trending performance metrics and outcomes,
   b. Data analysis,
   c. Identifying successful interventions and care pathways to optimize results, and

a. Making recommendations to refine processes and provide reports to the Division Medical Management Committee.

2. The Division shall perform an Operational Review of the AdSS to review compliance on an annual basis.

3. The Division shall develop a plan specifying short and long term strategies for improving care coordination and the Care Management program as specified in the MM Program workplan.

E. DIVISION RESPONSIBILITIES FOR THE HIGH NEEDS/HIGH COST PROGRAM

1. Health Care Services (HCS) shall annually review the list of Members from each AdSS that are identified as meeting the criteria for the HNHC program and approve Members to be monitored through the HNHC program. This is also to be done by HCS upon the AdSS proposing changes to the list.

2. HCS shall request additional Members identified by the Division to be added to the HNHC program when Members have high needs or high costs due to Long Term Services and Supports

(LTSS) who also have high medical or behavioral needs.

3. The Division shall submit to AHCCCS an overview of the HNHC program in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A as outlined in the contract.

4. The Division shall submit to AHCCCS counts of distinct members that are considered to have high cost behavioral health needs based on criteria developed by the AdSS and approved by the Division as outlined in the contract.

5. The Complex Care Manager shall annually review the High Cost Behavioral Health Reports (AMPM 1021 Attachment E) that the AdSS sends to the Compliance Unit, which is then forwarded to HCS.

6. The Complex Care Manager shall annually develop and submit an integrated High Cost Behavioral Health Report (AMPM 1021 Attachment E) reflecting data received from each AdSS to AHCCCS.

7. The Complex Care Manager shall annually send the High Cost Behavioral Health Report (AMPM 1021 Attachment E) to DDDAHCCCSDeliverables@azdes.gov.

8. HCS shall coordinate with the AdSS to ensure the assigned Support Coordinator and Behavioral Health Complex Care Specialist are invited to the monthly HNHC meetings.

9. The HCS Complex Care Nurse, assigned Support Coordinators and Behavioral Health Complex Care Specialists shall attend the monthly HNHC meeting to participate in the collaborative care coordination between the Division, AdSS, Care Manager, and provider case manager.

10. All attendees shall discuss the following care coordination activities during the monthly HNHC meetings:
    a. Identify Member specific interventions to be used to ensure:
        i. Relevant and timely access to care;
        ii. Care plan goals address the needs of the program

iii. Ineffective medical, behavioral health, and long-term care interventions are adjusted as needed; and

iv. Progress toward treatment goals is being achieved.

b. Address barriers to improvement, additional resources needed, and changes to treatment goals in the following areas:

i. Medical,

ii. Environmental,

iii. Behavioral Health, and

iv. Psychosocial.

11. The HCS Complex Care Nurse in collaboration with the AdSS, shall monitor Member outcomes to transition Members out of the HNHC program when they meet the following criteria:

a. The Member has met treatment goals, or

b. The Member's physical and behavioral needs have been stabilized, or

c. The Member no longer meets the AdSS HNHC criteria.

Signature of Chief Medical Officer: Anthony Dekker (Nov 2, 2023 08:16 PDT)

Anthony Dekker, D.O.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: April 10, 2024
REFERENCES: 42 CFR § 438.62(b); A.R.S. § 36-551; AMPM 1022; AMPM 541.

PURPOSE

This policy sets forth roles and responsibilities of the Division of Developmental Disabilities (Division) when facilitating the transition of Members with chronic or complex care needs out of jails and prisons into communities.

DEFINITIONS

1. "Care Management" is a group of activities performed to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
2. "Justice System Liaison" means a Division staff person who is located in Arizona and is the single point of contact for justice system stakeholders, such as jails, prisons, detention facilities,

courts, law enforcement, and community supervision agencies. This position is responsible for ensuring care coordination of justice-involved Members and for oversight and reporting of Justice System reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

5. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

POLICY

A. PROGRAM ADMINISTRATION REQUIREMENTS

1. The Division shall designate staff to serve in the role of Justice System Liaison who reach into the justice system to facilitate transitions for all Division Members out of justice facilities for the purposes of continuity of care.

2. The Justice System Liaison shall serve as the single point of contact when collaborating with justice system partners to identify, plan, and implement care coordination efforts for Members identified as requiring reach-in care.

3. The Justice System Liaison shall identify justice partners and their contact information, from the following:

    a. Jails;

    b. Sheriff's Offices;

    c. Correctional Health Services;

    d. Arizona Department of Corrections, Rehabilitation and

Reentry (ADCRR);

e. ADCRR Community Supervision;

f. Probation;

g. Courts; and

h. Other justice partners as determined by the Justice System Liaison.

4. The Justice System Liaison shall monitor the incarceration report, also known as the 834-file, in Focus in order to:

a. Identify Members who have been:

i. Incarcerated; or

ii. Otherwise released since the previous report.

b. Obtain length of Member incarceration from this report.

5. The Justice System Liaison shall collaborate with reach-in partners to determine Member care needs.

6. The Justice System Liaison shall collaborate with AdSSs through

the following measures:

a. Monthly meetings with each health plan to discuss mutual members;

b. Providing a Transition Notice Form to each MCO representative upon receiving notification of a member's justice involvement; and

c. Communicating with MCO's to address Member needs as identified.

7. The Justice System Liaison shall obtain the Member's criminal Justice Reach-In report from Focus in the quarter following the Member's release from the Justice System in order to:

a. Assess anticipated cost savings, including analysis of medical expenses prior to incarceration and subsequent to reach-in activities and release.

b. Report out in the Justice Quarterly Metrics the total amount saved or increased for all Members.

8. The Justice System Liaison shall notify AHCCCS upon becoming aware of a Member who becomes an inmate of a public institution, who is not identified in the 834 file, via email at MCDUJustice@azahcccs.gov.

B. REACH-IN CARE COORDINATION

1. The Justice System Liaison shall utilize the 834 file data provided by AHCCCS to identify Members who meet the Division's established parameters for reach-in care coordination, including identification of Medication Assisted Treatment (MAT) eligible Members prior to release.

2. The Justice System Liaison shall utilize additional data sources, if available for the purpose of identifying Members who meet the Division's established parameters for reach-in care coordination.

3. The Justice System Liaison shall utilize the 834 file provided By AHCCCS to identify incarcerated Members that may have missed their eligibility redetermination date while incarcerated, causing a discontinuance of benefits, in order to identify Members requiring assistance with reapplication for AHCCCS Medical

Assistance (MA) and other public benefits, in accordance with AMPM 541.

4. The Justice System Liaison shall complete the following activities upon identification of a Member's justice system involvement:

   a. Complete a Member intake utilizing Member data.

   b. Research the Member's legal case, utilizing jail or court websites to determine any pending court actions.

   c. Identify the Support Coordinator assigned to the justice involved Member to immediately inform the Support Coordinator of the justice involvement via email.

5. The Justice System Liaison shall coordinate with justice facility health care or subcontracted health plans in identifying Members requiring reach-in care for physical health, medication and behavioral concerns.

6. The Justice System Liaison shall begin reach-in activities for Members who have been incarcerated for 20 days or longer, and have a scheduled release date, to provide:

a. Member education regarding care, services, resources, appointment information; and

b. Subcontracted health plan case management contact information.

7. The Justice System Liaison shall communicate with incarceration facility health care and any subcontracted health plan to communicate the incarcerated Division Member's medication and behavioral concerns.

8. The Justice System Liaison shall contact and coordinate with Justice Partners and subcontracted health plans regarding status updates and anticipated release date or next court date, updating case file and entering shared notes into the database at least once weekly.

9. The Support Coordinator shall:

a. Acknowledge incarceration notification upon receipt from the Justice System Liaison, and update Member records.

b. Follow up with the Justice System Liaison to provide case

updates, including release or court date information.

c. Change Member status to "Suspend" in FOCUS when a Member has been incarcerated for 30 days or longer with no anticipated release date.

10. The Justice System Liaison shall monitor hearing information, noting date and type of hearing, entering this information into the database, and notifying Justice Partners of provided updates by email.

11. Division staff shall not appear on the Member's behalf, in the capacity of Division staff, in any court, unless a subpoena has been submitted through the Office of the Attorney General.

C. PRIOR TO RELEASE

1. The Justice System Liaison shall begin the release planning process upon receiving notification of the Member's anticipated release date.

2. The Justice System Liaison shall make Member education regarding care, services, resources, appointment information,

subcontracted provider and case management contact information available for the planning release meeting.

3. Division staff shall obtain from the Responsible Person a signed Authorization for Disclosure of Protected Health Information (DDD-1535A) that specifically identifies the person or organization intended to receive health information.

4. Justice System Liaison staff shall collaborate with Justice Partners to plan timeframes for appointments needed based on health status, to:

    a. Identify and address any barriers to accessing needed appointments; and

    b. Ensure initial appointments are scheduled to occur within seven days of Member release.

5. The Justice System Liaison shall communicate information regarding appointments to all Justice Partners and justice facility health care.

6. The Justice System Liaison shall review and address social

determinants of health prior to release through wrap-around services.

D. AFTER RELEASE

The Justice System Liaison shall continue reach-in activities post-release in effort to reduce recidivism to include:

a. Following up with the Responsible Person to support access to necessary services and appropriate service levels.

b. Following up with Justice Partners to communicate the status of appointments, within 30 days of release.

c. Monitoring the Member in the community until there is no longer any Justice involvement and the Member is reported to be stable in the community by the Planning Team.

E. OUTREACH TO COMMUNITY PARTNERS

The Justice Team shall provide specialized education to local law enforcement and other community partners to facilitate understanding

of developmental disabilities the populations served by the Division regarding the following:

a. Accommodating Division Members;

b. Safe interactions with Division Members;

c. Communicating with Division Members;

d. Effective engagement with Division Members;

e. Alternatives to the justice system for Division Members; and

f. De-escalation techniques.

F. REPORTING

1. The Justice System Liaison shall track data to be utilized by Division staff to create monthly, quarterly, and annual reports, identifying the number of Member transitions received, and other pertinent statistics, and trends.

2. The Justice Team designee shall provide data in the Division's Justice System Liaison reports at Medical Management meetings.

SUPPLEMENTAL INFORMATION

Division Members' AHCCCS health plan enrollment is suspended upon incarceration, and reinstated upon release.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:11 PDT)
Anthony Dekker, D.O.

1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551; AMPM 1023

PURPOSE

This policy outlines the requirements for the Division of Developmental Disabilities (Division) Disease/Chronic Care Management Program. The program focuses on members with chronic conditions, and/or at high risk, and may benefit from a targeted intervention plan.

DEFINITIONS

1. "Care Management" means a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

2. "Case Management" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Case Management

for DES/DDD is referred to as support coordination.

3. "Disease/Chronic Intervention Plan" means a protocol targeted at managing a disease/chronic condition and improving health outcomes.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

5. "Person Centered Service Plan" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

POLICY

The Division Disease/Chronic Care Management Program focuses on members with high need/high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The Disease/Chronic Care Management Program shall develop individualized intervention plans that include early identification of potential members, coordination of treatment, and chronic disease management strategies including education and self-management of conditions. The program shall work with Support Coordination, and the Administrative Services Subcontractors (AdSS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment.

A. CRITERIA FOR ENROLLMENT

A member is eligible for the program who:

1. Has been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;

2. Is identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;

3. Has one or more of the Fatal Five (aspiration; bowel obstruction, gastroesophageal reflux disease [GERD], dehydration, or seizures) conditions considered preventable causes of death in people with intellectual/developmental disabilities;

4. Has been diagnosed with post- Covid-19 condition(s); or

5. Has exhibited high or low utilization of services for high need conditions.

B. PROGRAM COMPONENTS

The Disease/Chronic Care Management Program provides a focused assessment of opportunities and development of an intervention plan to better manage disease or conditions for targeted members, improve health outcomes and quality of life.

Program activities include:

1. Screenings and assessments to identify high risk behaviors or emerging health issues, coordination of treatment, as appropriate, with the AdSS including but not limited to:

   a. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for qualified members, including

education and health promotion for dental/oral health services

b. Substance use

c. Depression

d. Tobacco use

2. Development of an individualized Disease/Chronic Condition Intervention Plan that involves working closely with the member and/or responsible person and obtaining their agreement with the plan. The plan includes the following components:

a. Goals.

b. Opportunities, interventions and resources to improve long term health outcomes.

c. Coordination with primary care provider/specialty care provider(s) and medical/behavioral treatment teams.

d. Regular contact by Health Care Services with the member and/or responsible person.

e. Evidence-based guidelines to enhance the health, wellness and quality of life of the member while reducing

the need for hospitalization and other costly treatments. Individualized targeted interventions designed to improve and sustain member engagement in treatment.

f. Actions to be taken by the member and/or responsible person.

g. Health education, resources and support tailored to the member's needs, including but not limited to:

i. Understanding chronic disease/conditions and improving health, wellness and quality of life

ii. Working with the care team, treatment/ services providers and allied supports

iii. Establishing and maintaining treatment relationships that foster consistent and timely interventions

iv. Understanding the member role in health and wellness

v. Healthy living and wellness programs

vi. Self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/ chronic conditions

vii. Health risk-reduction and healthy lifestyle choices, including tobacco cessation.

viii. Preventative care may include but is not limited to:

1) Health screening

2) Annual health exams

3) Cancer screening

4) Dental/oral health services.

5) OB/Gyn care

6) Maternity care programs and services for pregnant women.

3. Engagement, ongoing support and technical assistance with Support Coordination and the AdSS to integrate the Disease/Chronic Condition Intervention Plan into the person-centered service plan to support sustainability and continuity of care.

4. Once the health care services team determines the member to be ready for discharge, the member may be discharged from the disease/chronic care program. The Team is available for technical assistance and consultation to Support Coordination

and/or the AdSS to support the transition.

5. The member may be re enrolled based on the recommendation of Support Coordination, the AdSS and/or identified through HCS utilization reviews/reports.

C. OVERSIGHT

1. The Division collaborates with the AdSS to evaluate the effectiveness of the program by assessing the members' ability to self-manage their condition/disease and measuring other outcomes at predetermined points after enrollment. Other outcomes may include cost/utilization of services, clinical quality, and process measures.

2. The Division works in partnership with the AdSS to educate providers regarding the specific evidenced-based guidelines and desired outcomes of the program. The AdSS staff and providers may participate in the development of the Division specific evidence-based guidelines.

3. The Division monitors the AdSS to ensure provider compliance with the member Disease/Chronic Condition Intervention Plan and that appropriate corrective action is taken for any noncompliance.

4. Health Care Services shall track and trend performance metrics and outcomes identifying successful interventions and provide reports to the Division Medical Management Committee.

5. At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of the Disease/Chronic Care Management Program compliance.

Signature of Chief Medical Officer: _____
Anthony Dekker (Jul 11, 2022 14:17 PDT)
Anthony Dekker, D.O.

1024 DRUG UTILIZATION REVIEW

REVISION DATE: 3/27/2024
REVIEW DATE: 6/27/2023
EFFECTIVE DATE: July 13, 2022
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, 42 U.S.C 1396r-8, A.A.C. R9-22-209, 42 USC 1396A(OO), Social Security Act Section 1927 (g) Drug Use Review, AHCCCS Contract, AMPM 310-FF, AMPM 310-V, AMPM 1024.

PURPOSE

This policy outlines the Division's responsibility for the oversight of the Drug Utilization Review (DUR) process that includes retrospective, concurrent and prospective drug utilization edits developed and implemented by the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the

Division Program.

2. "Drug Utilization Review" or "DUR" means a systematic, ongoing review of the prescribing, dispensing, and use of medications. The purpose is to assure efficacious, clinically appropriate, safe and cost-effective drug therapy to improve Member health status and quality of care.

3. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the Division to provide all medically necessary Federal and State reimbursable drugs to the Member.

4. "Exclusive Provider" means an individual provider, which is chosen by the Member or assigned by the Division to provide all medically necessary Federal and State reimbursable drugs to the Member.

5. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person, including any act that constitutes Fraud under applicable State or Federal law.

6. "Prescription Drugs" means prescription medications prescribed by an Arizona Health Care Cost Containment System (AHCCCS) registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and State laws.

7. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. DRUG UTILIZATION REVIEW REQUIREMENTS

1. The Division shall require reporting for the following:
   a. Concurrent Drug Utilization Review (DUR);
   b. Opioid monitoring;
   c. Antipsychotic prescribing in children; and
   d. Identification of Fraud, Waste, and Abuse by either DDD

Members or health care practitioners.

2. The Division shall require DUR is performed to ensure that Members are receiving medications appropriately with limited adverse drug reactions.

3. The Division shall require DUR that consists of retrospective, concurrent and prospective DUR.

4. The Division shall require use of Arizona Health Care Cost Containment System (AHCCCS) Prior Authorization (PA) clinical guidelines.

5. The Division shall require opioid monitoring based per Federal regulations.

B. CONCURRENT UTILIZATION REVIEW

1. The Division shall require a concurrent DUR process be implemented that occurs between the pharmacies and the Pharmacy Benefits Manager's (PBM) electronic DUR system at the Point of Sale (POS).

2. The Division shall require concurrent DUR edits that include:

   a. Preferred and non-preferred Federally and State reimbursable drugs prior to dispensing;

   b. Drug-drug interactions;

   c. Excessive doses;

   d. High and suboptimal doses;

   e. Over and underutilization;

   f. Drug-pregnancy precautions;

   g. Drug-disease interactions;

   h. Duplicate therapy; and

   i. Drug-age precautions.

C. RETROSPECTIVE UTILIZATION REVIEW

1. The Division shall require a retrospective DUR process is implemented to detect aberrant prescribing practice patterns, pharmacy dispensing patterns and medication administration patterns to prevent inappropriate use, misuse, or Waste.

2. The Division shall require retrospective DUR reviews are performed to evaluate the following edits:
    a. Clinical appropriateness, use and misuse;
    b. Appropriate generic use;
    c. Drug-drug interactions;
    d. Drug-disease contraindications;
    e. Aberrant drug doses;
    f. Inappropriate treatment duration;
    g. Member utilization for over and underutilization;
    h. Prescriber clinician prescriptive ordering and practice patterns; and
    i. Pharmacy dispensing patterns.

D. PROSPECTIVE UTILIZATION REVIEW

1. The Division shall require the prospective DUR process be implemented to promote positive health outcomes using PA clinical guidelines to ensure clinically effective medications are prescribed in the most cost-efficient manner.

2. The Division shall require prospective DUR edits during the adjudication of a claim be enabled by the PBM for the following:
   a. Drug-allergy interactions;
   b. Drug-disease contraindications;
   c. Therapeutic interchange;
   d. Generic substitution;
   e. Incorrect drug doses;
   f. Inappropriate duration of drug therapy;
   g. Medication Abuse or misuse; and
   h. Medications preferred on the AHCCCS Drug List.

E. PRIOR AUTHORIZATION (PA) CLINICAL GUIDELINES

The Division shall require AHCCCS PA guidelines be utilized for any medications that require PA or are non-preferred medications.

F. PROVIDER EDUCATIONAL INTERVENTIONS

The Division shall require educational interventions based on evaluations of practice patterns focused on drug therapy outcomes

with the aim of improving safety, prescribing practices and therapeutic outcomes and ensuring the interventions improve quality of care.

G. EXCLUSIVE PHARMACY OR EXCLUSIVE PROVIDER PROGRAM

1. The Division shall require Members that are assigned to an Exclusive Pharmacy or Exclusive Provider, or both are reported on form AMPM 1024 Attachment A.

2. The Division shall provide AMPM 1024 Attachment A to AHCCCS as a quarterly deliverable when aberrant pharmacy or aberrant provider utilization is identified.

H. OPIOID UTILIZATION

1. The Division shall require DUR activities be performed as part of Federal Opioid Legislation, and reported to AHCCCS in accordance with the Centers for Medicare and Medicaid Services (CMS) DUR requirements as specified in the Contract for the following:

a. Opioid utilization and concomitant use of benzodiazepines;

b. Opioid utilization and concomitant use of antipsychotics;

c. Buprenorphine utilization and concomitant use of opioids;

d. 7-day limits for opioid naïve adults;

e. 5-day limits for opioid naïve minors;

f. 50 Morphine Equivalent Daily Dose (MEDD) limits for opioid naïve Members;

g. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90;

h. Antipsychotic prescribing for children; and

i. Fraud, Waste and Abuse by Members, pharmacies, and prescribing clinicians.

2. The Division shall require Members with a diagnosis of cancer, in hospice or palliative care be excluded from opioid safety edits and utilization management limitations associated with opioids.

I. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS;
   b. Review and analyze deliverable reports submitted by the AdSS; and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Mar 21, 2024 09:31 PDT)
Anthony Dekker, D.O.

1040 OUTREACH, ENGAGEMENT, AND REENGAGEMENT FOR BEHAVIORAL HEALTH

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 01, 2018
REFERENCES: AMPM Policy 320-R, AMPM Policy 320-U

Overview

The Division of Developmental Disabilities (Division) develops and implements outreach, engagement, and reengagement activities for members seeking and receiving behavioral health services. The Division develops and makes available to providers its policies and procedures regarding outreach, engagement, and reengagement, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Definitions

Engagement - For purposes of this policy, the establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness, and warmth.

Outreach activities - For purposes of this policy, activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services.

Reengagement - For purposes of this policy, activities by providers designed to encourage the individual to continue participating in services.

Policy

The Division will incorporate the following critical activities regarding service delivery within the AHCCCS System of Care:

A. Establish expectations for the engagement of members seeking or receiving behavioral health services,

B. Determine procedures to reengage members who have withdrawn from participation in the behavioral health treatment process,

C. Describe conditions necessary to end reengagement activities for members who have withdrawn from participation in the treatment process, and

D. Determine procedures to minimize barriers for serving members who are attempting to reengage with behavioral health services.

Community Outreach

The Division provides and participates in community outreach activities to inform members of the benefits and availability of behavioral health services and how to access them. Outreach activities conducted by the Division may include the following:

A. Participation in local health fairs or health promotion activities;

B. Involvement with local schools;

C. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events;

D. Development of outreach programs and activities for first responders (i.e. police, fire, EMT);

E. Regular contact with AHCCCS contractor behavioral health coordinators and primary care providers, especially the Division's Administrative Services Subcontractors;

F. Development of outreach programs to members experiencing homelessness;

G. Development of outreach programs to persons who are at risk, identified as a group with high incidence or prevalence of behavioral health issues, or underserved;

H. Publication and distribution of informational materials;

I. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs;

J. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers;

K. Development and implementation of outreach programs to identify members with co-morbid medical and behavioral health disorders and those who have been determined to have Serious Mental Illness (SMI) within the contractor's geographic service area; including persons who reside in jails, homeless shelters, county detention facilities or other settings;

L. Provision of information to behavioral health advocacy organizations; and

M. Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Behavioral health providers shall participate in engagement, reengagement, and follow-up processes as described in this policy.

Engagement

The Support Coordinator and/or Case Manager of the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facility must ensure active engagement by providers in the treatment planning process with the following:

A. The member and/or member's legal guardian;

B. The member's family or significant others, if applicable and amenable to the person;

C. Other agencies or providers, as applicable; and

D. For persons with a SMI who are receiving Special Assistance (see AMPM Policy 320-R), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Reengagement

The Support Coordinator takes the lead in the coordination with the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facilities to ensure reengagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services, or failed to appear for a scheduled service based on a clinical assessment of need. Provider Case Managers are available to assist Support Coordinators with reengaging members as deemed beneficial to their care. All attempts to reengage members must be documented in the member's file.

A. The behavioral health provider shall attempt to reengage the member by:

1. Communicating in the member's preferred language.

2. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g. after work or school).

3. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk.

4. Sending a letter to the current or most recent address requesting contact if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

5. Contacting the person designated to provide Special Assistance for his/her involvement in reengagement efforts for members determined to have a SMI who are receiving Special Assistance (see AMPM Policy 320-R).

B. If attempts to engage the member are unsuccessful, the Support Coordinator must ensure further attempts are made to reengage the member. Further attempts must include at a minimum, contacting the member or member's responsible person face to-face and contacting natural supports for whom the member has given permission to contact. All attempts to reengage members must be clearly documented in the member's case file.

C. If face-to-face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled, or gravely

disabled, the Support Coordinator must determine whether it is appropriate to engage the person to seek inpatient care voluntarily. If the member declines voluntary admission, the Support Coordinator must initiate the pre-petition screening or petition for treatment process described in AMPM Policy 320-U.

Follow-up After Significant and/or Critical Events

Discharge planning must begin upon notification that the member has been hospitalized. The Support Coordinator must ensure activities are documented in the member's case file and follow-up activities are conducted to maintain engagement within the following timeframes.

District nurses are available to assist Support Coordinators as considered beneficial to optimally meeting the needs of the individual member during their care transition:

A. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;

B. Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;

C. Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and

D. Changes in the level of care.

1200 OVERVIEW

REVISION DATE: 6/10/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36, 32-1, 36-2939(B)(1), 36-591(G); A.A.C. R6-6-901 - R6-6-910; C.F.R. §§ 42, and, 42-456.1.

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible member will receive services in accordance with documented needs and availability of State funds.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for members who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, types and amounts of support a member may receive. The person with a disability may request the Planning Team to help them identify what their needs are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person's services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan planning documents processes identifies needed services, members who are eligible for ALTCS shall receive information regarding their right to receive services as authorized.

Members who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the member their needs, the risk to the member if a gap in services were to occur and develop a contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the AHCCCS summarizing trends, services gaps, and related grievances.

Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

A. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.

B. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the member. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on a member basis to determine medical necessity as well as the cost effective level of care that will achieve the desired results. Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as small volume nebulizers suctioning, tracheostomy care.

Guidelines for services and evaluation criteria are found in the Service Approval Matrix (Prior Authorization). This information is available on the Division's website. https:/www.azdes.gov/main.aspx?menu=96&id=2470

The source information regarding each service is found in one of the following documents:

A. Chapter 42 Code of Federal Regulations. www.gpo.gov;

B. AHCCCS Medical Policy Manual. www.azahcccs.gov;

C. A.R.S. §36. www.azleg.gov/ArizonaRevisedStatutes.asp; or,

D. The Division Service Specifications.

1210 INSTITUTIONAL SERVICES AND SETTINGS

REVISION DATE: 8/15/2017, 7/15/2016, 5/13/2016, 2/12/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36-2939(A)(1), (B)(1), 36-591(G); A.A.C. R9-10-101, 42 CFR 409.31-35, 438.6(e), 440.40, 440.155, 456.1, 456.436, 483.75, 483.100-138, 483.400, 483.440; Division Medical Policy Manual, Policy 680-C Pre-Admission Screening and Resident Review; Division Operations Policy Manual, Policy 2001 Planning Team Members

The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS).

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities. ALTCS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. The Division uses an acuity tool to determine the level of institutional placement prior to placement.

Members who are eligible for the ALTCS transitional program are not eligible for Nursing Facility (NF) services or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services exceeding 90 continuous days per admission.

Nursing Facility

Service Description and Goals (Nursing Facility)

This service provides skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings (Nursing Facility)

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/ Medicaid certified.

Service/Provider Requirements (Nursing Facility)

The provider must demonstrate the following before the service is authorized:

A. The NF must be licensed and certified by the appropriate Arizona state agencies.

B. The NF must comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 *et seq*.

C. The NF must also comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

Admission Criteria (Nursing Facility)

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40.

B. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:

1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists

2. Daily skilled services that can only be provided in an NF, on an inpatient basis

3. Skilled services because of special medical complications

4. Services that are above the level of room and board.

C. The member must cooperate in a nursing assessment performed by the Division District Utilization Review Nurse prior to NF service being authorized.

D. The Pre-Admission Screening and Resident Review (PASRR) is completed pursuant to 42 CFR 483.100-138 (see Division Medical Policy Manual, Policy 680-C Pre-Admission Screening and Resident Review).

E. Prior to the authorization, the above criteria in this section must be met.

Exclusions (Nursing Facility)

A. The Division will authorize an NF placement only in a licensed and Medicare/Medicaid certified NF.

B. The Division will not pay for placement in an NF without prior authorization pursuant to 42 C.F.R 483.100 *et seq.* (see Division Medical Policy 680-C Pre-Admission Screening and Resident Review).

C. If the Primary Care Provider (PCP) or the Division District Utilization Review Nurse advises that the NF cannot meet the member's needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

D. If the Division places an NF on termination status:

1. No new members will be admitted to the NF.

2. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must identify contracted residential alternatives that are available to the member.

E. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.

F. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (Nursing Facility)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the NF.

A. Therapeutic leave includes leave due to a therapeutic home visit to enhance psychosocial interactions, a trial basis, or as a part of discharge planning, and is limited to 9 days per calendar year.

B. A bed hold includes medically necessary short-term hospitalization and is limited to 12 days per calendar year.

Reassessment for Continued Placement (Nursing Facility)

A. Members residing in an NF must be reassessed by the Division for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).

B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.

C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to update the current Planning Document to include:

1. The member's health and abilities

2. Current medication

3. Identification of needed Durable Medical Equipment (DME)

4. An updated Service Plan

5. A completed Cost Effectiveness Study (CES) based on anticipated service needs

6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division's Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member's previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division's Medical Director shall resolve disagreements regarding discharge planning.

E. The Division's Chief Medical Officer has the final authority as delegated by the Assistant Director.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Service Description (ICF/IID)

ICF/IID provides comprehensive and individualized health care, and habilitative and rehabilitative services, to members to promote functional status and independence for members who need, and are receiving, active treatment services that help the member obtain as much independence as possible.

Service Settings (ICF/IID)

An ICF/IID shall include the Arizona Training Program facilities, a state-owned and operated service center, state-owned or operated community residential settings, and private state-certified facilities that contract with the Department.

Service Provider/Facility Requirements (ICF/IID)

The provider must be state operated or contracted with the Division and demonstrate the following before the service is authorized:

A. The ICF/IID is registered with the Arizona Health Care Cost Containment System (AHCCCS).

B. The ICF/IID must be reviewed and certified annually by the Department of Health Services in accordance with 42 CFR 483.400.

C. The ICF/IID must comply with contract, all applicable federal and state laws, and DES and Division policies and procedures.

Admission Criteria (ICF/IID)

A. The ICF/IID service may be considered appropriate for a member who is in need of, or could benefit from, active treatment.

1. Active treatment includes continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that are directed toward:

a. The acquisition of the behaviors necessary for the member to function with as much self-determination as possible and the ability to live in a more independent setting

b. The prevention or deceleration of regression or loss of current optimal functional status.

2. Active treatment is provided continuously based on an individual member's assessed developmental needs that prevent the member from living in a more independent setting.

3. A continuous active treatment program includes interaction, between ICF/IID staff and the member, in which the member receives aggressive and consistent training, treatments, and supports during the normal rhythm of the member's day, whenever the need arises or an opportunity presents itself, in both formal and informal settings.

4. Examples of active treatment may include:

a. The application of a specific stimulation technique, to the area of the mouth of an individual with severe physical and medical disabilities, that decelerates the individual's rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth

b. Teaching the member to use an adaptive spoon and plate to eat independently

c. Acquisitions of behaviors for the member to function with as much self-determination and independence as possible

d. Teaching daily living skills.

5. Examples of what active treatment does not include:

a. Services to maintain generally independent members who are able to function with little supervision or in the absence of an active treatment program

b. Protective oversight for a member who is not in need of training for developmental deficits (e.g., a court placement to protect the community or the client from the client's behavior)

Programs to simply maintain a member's independence are not considered active treatment because the member is not learning to live in a more independent setting. If a member already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support, resources, and services that only an ICF/IID can provide, the member is considered generally independent and not in need of active treatment.

B. Prior to any permanent or temporary admission, the Division will complete a preliminary evaluation. The preliminary evaluation will consider background information as well as currently valid assessments of functional development, behavioral, social, health, and nutritional status and assessed needs that are prohibiting the member from living in a more independent setting and which require intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The Division will review all necessary medical or other documentation to support the need for admission into an ICF/IID. This information may include the Planning Document, Placement Profile and, if the member receives nursing or therapies, the Nursing Assessment and Therapy evaluations/reports. If any additional information (e.g., medical records) is required, the Division's HCS will contact the Support Coordinator.

C. The Division will determine whether there are alternative placements that are less restrictive and more cost effective than the requested ICF/IID placement. The alternative options shall be discussed with the member and/or their responsible person before a final decision is made by the Division.

D. A Cost Effectiveness Study must be completed prior to admission.

E. A written ICF/IID placement approval from the Assistant Director or the Assistant Director's Designee is required prior to authorization.

<u>Development and Implementation of the Active Treatment Plan (ICF/IID)</u>

A. Pursuant to 42 CFR 483.440, within 30 days after admission:

1. A comprehensive functional assessment of the member is completed.

2. As a result of the comprehensive functional assessment, specific objectives necessary to meet the member's needs will be identified.

3. A written active treatment program specific to the member will be designed and implemented.

B. Data documentation of the specific objectives must be in measurable terms.

C. The initial active treatment plan must be reviewed by a Qualified Intellectual Disability Professional/Support Coordinator, the Planning Team, and revised as necessary.

D. During the annual planning meeting the comprehensive functional assessment shall be reviewed for relevancy and updated as needed.

Exclusions (ICF/IID)

ICF/IID placements shall not be made when any of the following are true:

A. The member's needs can be met in a less restrictive and more cost-effective HCBS option.

B. The member does not need active treatment in an ICF/IID.

C. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.

D. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (ICF/IID)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the ICF/IID.

A. Therapeutic Leave includes leave due to a therapeutic home visit to enhance psychosocial interactions or on a trial basis or as a part of discharge planning and is limited to 9 days per calendar year.

B. A bed hold includes when short-term hospitalization is medically necessary and is limited to 12 days per calendar year.

Continued Stay Reviews (ICF/IID)

A. The Division completes "Continued Stay Reviews" pursuant to 42 CFR 456.436 and "Active Treatment Reviews."

B. The "Continued Stay Reviews" and "Active Treatment Reviews" will be completed at least every six months, and the following will be considered:

1. The member no longer needs, and will not benefit from, continued active treatment in an ICF/IID.

2. The member requires protective oversight only.

3. The member is able to function with little supervision in the absence of an active treatment program.

4. A less restrictive and more cost effective level of service or living situation would meet the needs of the member as determined by the Planning Team.

Service Closure (ICF/IID)

ICF/IID services may be terminated:

A. As determined by the Continued Stay Review

B. As necessary for the member's welfare and when the needs of the member cannot be met in the ICF/IID

C. When the member has met their outcomes and no longer needs the services provided by the ICF/IID

D. At the request of the member/responsible person

E. When the member is no longer eligible for ALTCS

F. When the criteria in the Admission Criteria (ICF/IID) section in this Policy are no longer met

G. When the ICF/IID is no longer operating and a less restrictive or more cost effective level of service or living situation can meet the needs of the member.

The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a team meeting must occur to update the member's current Planning Document to include:

   1. The member's health and abilities

   2. Current medication

   3. Identification of needed Durable Medical Equipment (DME)

   4. An updated Service Plan

   5. A completed Cost Effectiveness Study based on anticipated service needs

   6. Needed follow up medical appointments.

B. The Planning Team shall include the member or responsible person, the Division's HCS nurse, the Support Coordinator, and representatives from the ICF/IID. The team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member's living arrangement needs to change from what it was previously, the Support Coordinator makes the request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

D. The member or responsible person, the PCP, attending Physician and the Division's Chief Medical Officer shall resolve disagreements regarding discharge planning and service closure.

E. The Division's Chief Medical Director shall have the final authority as delegated by the Assistant Director.

Behavioral Health

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

Behavioral Health Inpatient Facility

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

Institution for Mental Disease (IMD)

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit

B. Medical/acute care services as specified in this Policy Manual.

1230-A ASSISTED LIVING FACILITIES

REVISION DATES: 10/28/2020, 7/15/16, 7/3/15
EFFECTIVE DATE: June 30, 1994

PURPOSE

This policy establishes requirements for Assisted Living Facilities designed for ALTCS members who are physically or functionally unable to live in their own home, but do not need the care intensity of a nursing facility.

DEFINITIONS

Alternative Home and Community Based Services (HCBS) Setting means a living arrangement where a member may receive HCBS. The setting shall be approved by the director, and either 1) Licensed or certified by a regulatory agency of the state, or 2) Operated by the Indian Health Services (IHS), an Indian tribe or tribal organization, or an urban Indian organization, and has met all applicable standards for state licensure, regardless of whether it has actually obtained the license. The possible types of settings include:

- Community residential settings
- Group Homes
- State-operated Group Homes
- Developmental Homes
- Behavioral Health Therapeutic Homes
- Behavioral Health Respite Homes
- Substance Abuse Transitional Facilities

Assisted Living Center (ALC) means an assisted living facility that provides resident rooms or residential units to eleven or more residents. Assisted Living Centers may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

> **Supervisory Care Services** means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis, and assistance in the self-administration of prescribed medications.
>
> **Direct Care Services** means programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions.
>
> **Personal Care Services** means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15, or as otherwise provided by law.
>
> **Assisted Living Home (ALH)** means a facility that provides resident rooms and services to ten or fewer residents.

Assisted Living Facility (ALF) means a residential care institution that provides supervisory care service, personal care services or direct care services on a continuing basis. All approved residential settings in this category are required to meet ADHS licensing criteria as defined in A.A.C R9-10 Article 8.

POLICY

A. CONSIDERATIONS

To ensure the appropriateness of a placement in a facility, the following shall be considered and documented:

1. Member is over the age of 60; however, the team can recommend exceptions for approval by the Assistant Director;

2. A nursing home is the only other alternative available or the team feels a facility best meets the needs, desires, and capabilities of the member;

3. Alternate placements were considered and the reason why they were not appropriate is documented. Facility placement cannot be the only placement option considered and cannot be used as an "emergency" placement alternative;

4. Member/responsible person clearly understands the alternative placement options;

5. Member/responsible person, and the Support Coordinator have visited the proposed facility;

6. Member will be placed with a similar age group as the other members living in the facility and not be segregated based on disability;

7. The supports identified in the Planning Document can be provided by the Center;

8. The member shall be given the choice to live with or without a roommate. The Support Coordinator will document this choice on the Assisted Living Facility/Single Occupancy Form. This form shall be filed with the Planning Document and be reviewed annually. At any time, the member may contact his/her Support Coordinator to revise the choice to live with or without a roommate. When this occurs the Support Coordinator shall update the form;

9. The Support Coordinator and others can monitor the facility at any time. Monitoring by the Support Coordinator, through on-site visits, will be conducted at least every 30 days for the first quarter and every 90 days thereafter; and

10. The District Program Manager/designee reviewed the required documentation and concurs the considerations have been met prior to the authorization of services.

B. CONDITIONS

When identifying potential facilities, the following conditions are recommended:

1. Private room (unless the member chooses to have a roommate as noted above),
2. Room includes a private in-room bathroom (unless the member chooses to have a roommate as noted above),
3. Space allows for separation of sleeping and living areas,
4. An inside door lock,
5. Food preparation space,
6. Doorbell or door knocker,
7. Individual mailbox,
8. Variety of on-site and off-site events from which to choose,
9. Transportation,
10. Indoor and outdoor common areas,
11. Weekly housekeeping service,
12. Weekly laundry service, and
13. Monthly newsletter or calendar of events.

C. EXCLUSIONS

1. Under no circumstance will a facility be used for Respite.
2. Although Assisted Living Facilities are required to provide room and board, room and board is not a Division-covered service for these facilities. The room and board amount shall be the responsibility of the member/ representative payee.

1230-C COMMUNITY RESIDENTIAL SETTINGS AND ROOM AND BOARD

REVISION DATE: 4/21/2023, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

PURPOSE

This policy establishes an overview of Community Residential Settings and Room and Board. This policy applies to ALTCS members.

DEFINITIONS

1. “Adult Developmental Home (ADH)” means the same as in A.R.S. § 36-551.
2. “Child Developmental Certified Home" means the same as in A.R.S. § 36-551.
3 "Child developmental home" means the same as in A.R.S. § 36-551.
4 “Community Residential Setting” means the same as in A.R.S. § 36-551.
5 “Group Homes” means the same as in A.R.S. § 36-551.
6 “Home and Community-Based Services Final Rule” means the final rule issued by the Center for Medicare and Medicaid

Services that ensures people receiving HCBS have full access to the benefits of community living and are able to receive services Community Developmental Disability Services are subject to this rule. The rule is also known as the HCBS Settings Rule.

7. “Member” means an individual who is receiving services from the Division of Developmental Disabilities (Division).
8. "Nursing-supported group home" means the same as in A.R.S. § 36-401.
9. “Room and Board” means a service that provides for the basic necessities that Members living in Community Residential Settings need to have in place to benefit from Community Residential Settings services, including a safe and accessible living environment, food, and utilities.
10. “Service Provider” means the same as in A.R.S. § 36-551.

POLICY

A. COMMUNITY RESIDENTIAL SETTINGS

1. The Division shall contract with service providers for Community Residential Settings to provide a safe, homelike family

atmosphere that meets the physical and emotional needs of DDD members.

2. The Division shall operate Community Residential Settings as outlined in A.R.S. § 36-558.
3. The Division shall cover Community Residential Settings when medically necessary and cost effective.
4. The Division assesses for and authorizes members for Community Residential Settings.
5. The Division shall ensure that Members who live in a Community Residential Settings have habilitation outcomes in their service plan to improve or learn new skills.
6. The Division shall cover physical health and behavioral health services by other providers when those services are not included in the scope of services provided by the Community Residential Setting.

B. ADULT AND CHILD DEVELOPMENTAL HOMES AND CHILD DEVELOPMENTAL CERTIFIED HOMES

1. The Division shall contract with service providers to develop and provide oversight to Adult and Child Developmental Homes.

2. The Division shall license providers of developmental home services for each Adult and Child Developmental Home.
3. The Division shall contract with Service Providers to develop and provide oversight to Child Developmental Certified Homes that are licensed by the Department of Child Safety and certified by the Department of Economic Security, Office of Licensing Regulation and Certification for up to three members.
4. The Division shall assess for Adult and Child Developmental Homes or Adult and Child Developmental Certified Homes when a member needs a licensed residential setting where:
    a. The provider(s) and other family members live in the home.
    b. Members need some help with daily care needs and learning, but do not need much support during sleeping hours.
    c. Transportation to day programs, work activities, and events outside the home is provided.

C. GROUP HOMES, NURSING SUPPORTED GROUP HOMES, AND ENHANCED BEHAVIORAL GROUP HOMES

1. The Division shall contract with service providers to develop and operate Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes.
2. The Division shall ensure the Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes are licensed by the Arizona Department of Health Services.
3. The Division shall assess for Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes when a member needs a licensed residential setting where:
    a. Staff rotate shifts 24-hours a day to meet a member's needs and help them learn skills.
    b. Members need more assistance with independent skills, including cleaning, hygiene, self-help, and behavioral support.
    c. Transportation to day programs, work activities, and events outside the home is provided.
4. The Division may assess for a Nursing Supported Group Home when a Member requires skilled nursing services as assessed by the Division's Healthcare Services staff.

5. The Division may assess for an Enhanced Behavioral Group Home when a Member requires time-limited intensive behavioral support as assessed by the Division's Healthcare Services staff.

D. ROOM AND BOARD

1. The Division shall assess and pay for the Community Residential Setting based on the Contracted Rate for the residential services using state funds.
2. The Division shall determine Member's responsibility for Room and Board, and bill the Member for their share of the cost per DDD Residency Agreement.
3. Support Coordinator shall complete the DDD Residency Agreement prior to a Member moving into a Community Residential Setting.
4. The Division shall ensure that providers comply with HCBS Settings rules requirements outlined in the Provider Manual Chapter 2.

Signature of Chief Medical Officer: Anthony Dekker (Apr 17, 2023 12:07 PDT)
Anthony Dekker, D.O.

1240-A ATTENDANT CARE AND HOMEMAKER (DIRECT CARE SERVICES)

REVISION DATE: 2/26/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Attendant Care

Description

This service provides assistance for a member to remain in their home and participate in community activities by attaining or maintaining personal cleanliness, activities of daily living, and safe and sanitary living conditions.

Barring exclusions noted in this section, Attendant Care (ATC) may include the following as determined by the member's assessed needs:

A. Meal preparation and clean up (e.g., meal planning, preparing foods, special diets, clean-up, and storing foods);

B. Eating and assistance with eating;

C. Bathing (e.g., washing, drying, transferring, adjusting water, and setting up equipment);

D. Dressing and grooming (e.g., selecting clothes, taking off and putting on clothes, fastening braces and splints, oral hygiene, nail care, shaving, and hairstyling);

E. Toileting (e.g., reminders, taking off and putting on clothes and/or undergarments, cleaning of catheter or ostomy bag);

F. Mobility (e.g., physical guidance or assisting with the use of wheelchair);

G. Transferring;

H. Cleaning;

I. Laundry (e.g., putting clothes in washer or dryer, folding clothes, putting away clothes);

J. Shopping (e.g., grocery shopping and picking up medications);

K. Attending to certified service animal needs; and,

L. General supervision for a member who cannot be safely left alone. (See Appendix A, B and C.)

Responsible Person's Participation (Attendant Care)

The member/family is responsible to provide:

A. Needed supplies (e.g., cleaning supplies) or money for supplies. Money must be provided in advance when the Attendant Care provider is expected to shop for food, household supplies, or medications; and,

B. Documentation required for the approval of this service.

Considerations (Attendant Care)

When assessing the need for this service, the following factors will be considered:

A. Due to advancing age, a temporary or permanent documented physical or cognitive/intellectual disability or documentation of other limitation, the parent or guardian cannot meet a child's basic care needs;

B. Due to the child's intensive medical, physical, or behavioral challenges, which are a result of the disability, the parent or guardian cannot meet the child's care needs;

C. The child, due to a medical condition or procedure related to the disability, is unable to attend their school/work/day program, and natural support(s) is/are unavailable to provide care;

D. The adult member is unable to meet specific, basic personal care needs;

E. The adult member lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness;

F. The members' needs are not currently met due to unavailability of service. Attendant Care may be used as an alternative service;

G. The member has medical or physical needs, was living in a Developmental Home, Group Home, Intermediate Care Facility, Nursing Facility, or other out of home placement, and with Attendant Care, the member will be able to return home;

H. When a spouse provides Attendant Care, the total hours of Attendant Care may not exceed 40, regardless of who provides the care. In addition, the member may not receive any similar or like service (i.e., Homemaker). (Habilitation services are not a similar or like service.);

I. Attendant Care services are subject to monitoring and supervision as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy; and,

J. When a family member requests to become the Attendant Care Provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Settings (Attendant Care)

Attendant Care Services may only be provided:

A. In the member's home (unlicensed);

B. In an Independent Developmental Home when there is a specific issue, problem, or concern that is believed to be temporary or short term, and the service is approved by the Assistant Director/designee; and,

C. In the community:

1. While accompanying the member; or,

2. While shopping or picking up medications.

Exclusions (Attendant Care)

Exclusions to the authorization of Attendant Care service are indicated below. Exceptions shall be approved by the District Manager.

A. The Attendant Care Service:

1. Shall not substitute for private pay day care or a school program for children;

2. Shall not cover before and after school care needs, days when there is no school, half school days, holidays, or summer and winter breaks, or for 'babysitting' unless a child meets the criteria for supervision;

3. Shall not be provided for acute illnesses that prevent the child from attending private daycare or school;

4. Shall not be provided while the member is hospitalized;

5. Shall not substitute for Work, Day Program, Transportation, or Habilitation, unless those services are not available to the member;

a. When used as a substitute, Attendant Care shall be used only until an appropriate service is available; or,

b. When the appropriate service has been refused, Attendant Care cannot be used as a substitute.

6. Shall not substitute for Respite;

7. Shall not be received during the provision of a Division funded Employment or Day Program;

8. Shall not be used to avoid residential licensing requirements; and,

9. Shall not be used to take the place of care provided by the natural support system for children.

B. The tasks below are not included as part of the Attendant Care Service:

1. Cleaning up after parties (e.g., family celebrations and holidays);

2. Cleaning up several days of accumulated dishes;

3. Preparing meals for family members;

4. Routine lawn care;

5. Extensive carpet cleaning;

6. Caring for household pets;

7. Cleaning areas of the home not used by the member (e.g., parents' bedroom or sibling's bathroom);

8. Skilled medical tasks. (See Appendix D – Skilled Nursing Matrix.); and,

9. Shopping for a child living in the family home.

The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry.

Homemaker (Housekeeping)

Service Description and Goals (Homemaker)

This service provides assistance in the performance of activities related to routine household maintenance at a member's residence. The goal of this service is to increase or maintain a safe, sanitary, and/or healthy environment for eligible members.

Service Settings (Homemaker)

This service would occur in the member's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

Service Requirements (Homemaker)

Before Homemaker can be authorized, the following requirements must be met:

A. Safe and sanitary living conditions shall be maintained only for the member's personal space or common areas of the home the member shares/uses.

B. Tasks may include:

1. Dusting;

2. Cleaning floors;

3. Cleaning bathrooms;

4. Cleaning windows (if necessary to attain safe or sanitary living conditions);

5. Cleaning oven and refrigerator (if necessary to prepare food safely);

6. Cleaning kitchen;

7. Washing dishes;

8. Changing linens and making beds; and,

9. Routine maintenance of household appliances.

A. Washing, drying, and folding the member's laundry (ironing only if the member's clothes cannot be worn otherwise).

B. Shopping for and storing household supplies and medicines.

C. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:

a. Heavy cleaning such as washing walls or ceilings; and,

b. Yard work such as cleaning the yard and hauling away debris.

2. Assist the member in obtaining and/or caring for basic material needs for water heating and food by:

a. Hauling water for household use;

b. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes; and,

c. Caring for livestock used for consumption including feeding, watering and milking.

3. Provide or ensure nutritional maintenance for the member by planning, shopping, storing, and cooking foods for nutritious meals.

Target Population (Homemaker)

Members who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. Members who are not eligible for Arizona Long Term Care Services (ALTCS) should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by a member and/or his/her caregiver. It is important to remember that housekeeping services are based on "assessed need" and not on a person's or the family's stated desires regarding specific services.

Consideration should be made to age appropriate expectations of the member and his/her entire family (what can reasonably be expected of each member based on his/her age). The team should consider the natural supports available and not supplant them. In addition

to the guidelines found in this section, there may be a need for the SPP if any of the following are factors:

A. A member is living with his/her family and has intense medical, physical, or behavioral needs; and the family members are unable to care for the member and maintain a safe and sanitary environment;

B. A member is living with his/her family and the family members have their own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required);

C. A member is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment;

D. A member is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the member's abilities may be maximized; and,

E. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the member's progress notes and the service delivery would be of a time-limited nature.

Exclusions (Homemaker)

The following exclusions apply to the provision of Homemaker:

A. Homemaker is to be performed only for the members' areas of the home or common areas of the home used by the member, e.g., parents' or siblings' bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Homemaker services include:

   1. Cleaning up after parties;

   2. Cleaning up several days of accumulated dishes;

   3. Preparing meals for the whole family; and,

   4. Routine lawn care.

B. Homemaker shall not be provided to members residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for Persons with an Intellectual Disability or Level I or Level II Behavioral Health Facilities.

Service Provision Guidelines (Homemaker)

Typical utilization of Homemaker would be two to four hours per week. Additionally:

A. The member or family is expected to provide all necessary supplies;

B. This service shall not be provided when the member is hospitalized or otherwise receiving institutional services. The service may only be provided at the end of hospitalization to allow the member to return to a safe and sanitary environment; and,

C. Members residing in Group Homes, Foster Homes or Adult Developmental Homes shall not receive this service.

Utilization of Homemaker will be in accordance with the Service Authorization Matrix.

Provider Types and Requirements (Homemaker)

Designated District staff will ensure all contractual requirements related to Homemaker providers are met before services can be provided. Additionally, all providers of ALTCS must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Homemaker)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support Coordinator's observation and input from the member, family, and provider.

Service Closure (Homemaker)

This service is no longer appropriate when:

A. The member's medical, physical or behavioral needs have decreased;

B. The physical/medical needs of the family members have decreased;

C. The family is no longer experiencing crisis;

D. The member no longer resides at home, has moved out of state, or when the member is no longer eligible for ALTCS;

E. The member moves to a residential or institutional setting; or,

F. The family has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

Other Homemaker Services

A. The amount of Homemaker provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible member resides in the home, payment will not be made twice for cleaning common areas of the home.

B. If the family is receiving supplemental payments for other members in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.

1240-C COMMUNITY TRANSITION SERVICES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Description

The Community Transition Service (CTS) assists members eligible for Arizona Long Term Care System (ALTCS) to reintegrate into the community by providing financial assistance to move from an ALTCS setting to their own home or apartment, excluding licensed community settings.

An ALTCS setting includes one of the following:

A. Behavioral Health Level I facility;

B. Institution for Mental Disease;

C. Inpatient Psychiatric Residential Treatment Center (available to members under 21 years of age eligible for Title XIX.);

D. Nursing Facility, including religious non-medical health care institution; and,

E. Intermediate Care Facility (ICF).

The following items can be purchased using CTS funds:

A. Security deposits required to obtain a lease on an apartment or home (refunded deposits are the property of the Division);

B. Essential furnishings (new or gently used including items such as: bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances);

C. Moving expenses; and,

D. Set up fees or deposits for utility or service access (e.g., telephone, electricity, gas). (Refunded deposits are the property of the Division.)

Considerations

The following factors will be considered when assessing the need for this service:

A. The member has been living in an ALTCS setting a minimum of 60 consecutive days regardless of ALTCS enrollment;

B. The member is within 30 days of being discharged into the community; and,

C. The LTC setting discharge plan identifies needs and assistance for which the member has no other source or support to move.

1. It is not intended to replace items or supports otherwise provided by the Division or community resources.

2. The members' needs shall be met upon discharge and discharge cannot be delayed in anticipation of receiving services from other sources (e.g., when coordinating with other community sources for the provision of this service).

Exclusions

Community Transition Services are:

A. Not available to members moving from an ALTCS setting to an alternate residential setting such as Assisted Living Facilities, Group, or Developmental Homes;

B. Limited to a one-time authorization (see exception letter C below) of up to $2,000 every five years per member;

1. The $2,000 includes all applicable administration fees.

2. The five year timeframe applies regardless of changes in Managed Care Contractors or the member transfers between fee-for-service and managed care.

C. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ALTCS institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case-by-case basis.

D. Not dispersed to the member, the member's family, or friends.

1. Funds are paid directly to the vendor identified by the member or family.

2. Receipts for all purchases using CTS funds shall be retained for a minimum of five years.

3. The Support Coordinator will assist the member and family with prioritization of needs and facilitate the purchase of identified goods and services.

The following items cannot be purchased using CTS funds:

A. Cash payments to members or significant others;

B. Rent;

C. Leisure/recreational devices (e.g., television or cable access, internet access, stereo);

D. Aesthetics/decorative items (e.g., picture frames, rugs);

E. Remodeling improvements to any home or apartment; and,

F. Grocery items (e.g., food, personal hygiene, cleaning products).

1240-D EMERGENCY ALERT SYSTEM

REVISION DATE: 10/26/22, 3/2/15
EFFECTIVE DATE: June 30, 1994
REFERENCES: AMPM 1240-D

PURPOSE

This policy establishes requirements for the coordination and provision of emergency alert systems to Members eligible for the Arizona Long Term Care System.

DEFINITIONS

1. "Emergency Alert System" (EAS) means a service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone or would be alone for intermittent periods of time without contact with a service provider, family member, or other support systems, putting the member at risk.
2. "Member" means an individual enrolled with the Division.
3. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary;

and any person selected by the Member, Responsible Person, or the Department.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. The Division of Developmental Disabilities (Division), shall cover EAS for Members who meet all of the following criteria:

1. The Member lives alone or is alone for intermittent periods of time without contact with a service provider, family member, or other support system;
2. The Member's community does not have reliable/available emergency assistance on a 24-hour basis;
3. The assessment of the Member's medical and/or functional level documents an acute or chronic medical condition;
4. The Primary Care Provider (PCP) has prescribed the EAS; and
5. The Member has the ability to use and operate the system.

B. The Division shall subcontract the management of EAS to the Administrative Services Subcontractors (AdSS) for Members enrolled in AdSS health plans.

C. The Support Coordinator, when a Member enrolled in a subcontracted health plan requests an EAS or the Planning Team identifies the need for one, shall:

1. Advise the Member to contact their PCP for a prescription.
2. Coordinate the service as per the subcontracted health plan's referral process.
3. Follow the Health Escalation Path if the Member experiences difficulty obtaining an EAS.

D. The Support Coordinator, when a Member enrolled in the Tribal Health Program requests an EAS or the Planning Team identifies the need for one, shall:

1. Advise the Member to contact their PCP for a prescription.
2. Coordinate the service as per the Arizona Health Care Cost Containment System referral process.

E. The Support Coordinator shall document all actions pertaining to the coordination of EAS in the Member's case file.

Signature of Chief Medical Officer: Anthony Dekker (Oct 19, 2022 10:25 PDT)
Anthony Dekker, D.O.

1240-E HABILITATION SERVICES AND DAY TREATMENT SERVICES

REVISION DATE: 5/31/23, 9/11/2019, 9/15/2017, 7/15/2016, 7/3/2015, 3/2/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: AMPM 1240-E, Division Medical Policy 1240-J

PURPOSE

This policy outlines the requirements for and describes covered hourly and daily Habilitation services and Day Treatment Services for Division Members who are eligible for Arizona Long Term Care Services (ALTCS).

For the purpose of this policy, Daily Habilitation is Habilitation provided in a Member's Own Home or community setting. Daily Habilitation may also be referred to as Supported Living or Independently Designed Living Arrangement (IDLA).

DEFINITIONS

1. "Community Residential Setting" means the same as in A.R.S. § 36-551.

2. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an

individual is:

a. Compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience;

b. Receiving the same level of benefits provided to other employees without disabilities in similar positions;

c. At a location where the employee interacts with other individuals without disabilities; and

d. Presented opportunities for advancement similar to other employees without disabilities in similar positions.

3. “Day Treatment” means a service that engages Members in their communities to develop, or enhance skill development, for activities of daily living and employment while meeting their specialized sensorimotor, cognitive, communication, social interaction, and behavioral needs and foster the acquisition of skills explore their communities, to learn about their interests, to engage with others, and to gain skills needed for greater

independence.

4. “Direct Care Worker (DCW)” means An individual who assists an elderly individual or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies or, in the case of member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

5. “Habilitation” means the process by which an individual is assisted to acquire and maintain those life skills that enable the individual to cope more effectively with personal and environmental demands and to raise the level of the individual’s physical, mental, and social efficiency as specified in A.R.S. § 36-551 (18).

6. “Home and Community Based Services (HCBS)” means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.

7. “Member” means a person enrolled with the Division of

Developmental Disabilities.

8. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

   a. Health care institution under A.R.S. § 36-401.

   b. Residential care institution under A.R.S. § 36-401.

   c. Community residential setting under A.R.S. § 36-551, or

   d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

9. "Planning Document" means a plan which is developed by the planning team, such as an Individualized Family Service Plan (IFSP) or Person Centered Service Plan (PCSP).

10. "Planning Team" means a group of individuals that shall include the Member, Responsible Person, Support Coordinator, and a

representative from the agency for Member's living in a licensed setting and with the Member's consent, and any individuals important in the Member's life, including but not limited to, extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team Members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the Member.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. HABILITATION SERVICES

1. The Division shall contract with service providers to provide Habilitation services to Division Members.

2. The Division shall cover Habilitation services when medically necessary and cost effective.

3. The Division shall assess for and authorize Habilitation services when a need for Habilitation services has been identified by the Planning Team.

4. The Division shall ensure that Members assessed for Habilitation have Habilitation outcomes, based on the Responsible Person's priorities and goals, identified in the Planning Document to improve or learn new skills.

B. HOURLY AND DAILY HABILITATION

1. The Support Coordinator may assess for Hourly or Daily Habilitation when the Member has outcomes in their Planning Document that require a service to support the Member in:

a. Independence and socialization skills

b. Safety and community skills

c. Member's health and safety.

d. Essential activities required to meet the Member's personal and physical needs

e. Alternative and/or adaptive communication skills

f. Self-help/living skills

g. Developing the Member's support system to reduce the need for paid services.

h. Helping family members learn how to teach the Member a new skill.

i. Developing skills for independent living in their home, including adaptive and self-determination skills, while offering supervision and assistance to assure their health and safety.

j. To socialize with their housemates, their family, their

friends, and community members.

2. The Support Coordinator shall consider the following when assessing for Hourly or Daily Habilitation:

   a. Existing community support systems have been exhausted and no other service is available.

   b. The Member's documented needs cannot be met by the Member's informal support system, employment program, or Day Treatment program.

   c. When the Member requires Habilitation to support their home program strategies for therapy services.

   d. Members want to live as independently as possible and develop or enhance their independence in their home, participation in their community, and relationships with others.

4. The Division shall authorize Habilitation Hourly or Daily Habilitation in the following settings:

   a. The Member's Own Home;

b. A community setting chosen by the Responsible Person;

c. The setting where the expected skills shall be applied;

d. In a Direct Service Provider's (DSP) residence when the residence is also the Member's Own Home.

5. The Division shall not authorize Hourly or Daily Habilitation in the following settings:

a. During the time the Member is attending Day Treatment and Training, or

b. To substitute for Day Treatment and Training services;

c. In a Qualified Vendor owned or leased service site;

d. When the Member is hospitalized;

e. To Members living in a Community Residential Setting, skilled nursing facilities, non-state operated Intermediate Care Facilities, or Level I or Level II behavioral health facilities;

f. Habilitation Hourly and Habilitation Daily shall not be

approved concurrently

g. In schools or while being transported by the school.

g. Substitute for Respite

h. Substitute for daycare

i. Be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B

j. Be used when another service is more appropriate

k. In a Direct Service Provider's (DSP) residence when the residence is not the Member's Own Home.

B. DAY TREATMENT SERVICES

1. The Division shall ensure that Day Treatment programs shall follow guidelines for language competency and provide rights and resources in a location that anyone can access at any time for reference or in the event they feel their rights are being violated.

2. The Support Coordinator shall consider the Member's ability to

gain Competitive Integrated Employment as part of the Employment First Initiative prior to assessing for Day Treatment services, refer to Division Medical Policy 1240-J.

3. The Support Coordinator, after consideration of any employment and educational services, may assess for Day Treatment services.

4. The Support Coordinator shall assess for Day Treatment Child for children through the age of 17 years old.

    a. Upon the age of 16 years old, transition plans may be individually developed, and may permit the inclusion into services with adults with consent from the Member's Responsible Person.

    b. The transition plan and consent shall be available to the Division upon request.

5. The Support Coordinator shall assess for Day Treatment Adult for Members who are 18 years old and older.

6. The Support Coordinator shall not assess for Day Treatment

services for Members to:

a. Substitute for Respite or day care

b. Be used in place of regular educational programs as provided under Public Law 105-17 (www.gpoaccess.gov/plaws/)

c. Be used to provide other related services that have been determined in the IEP to be educationally necessary

d. Be used when another service is more appropriate

e. Include wage-related activities that would entitle the member to wages.

5. The Division shall authorize Day Treatment services in the following settings.

a. A setting owned or leased by the Qualified Vendor that includes planned opportunities for interaction with community members and resources, and the home program allows for participation in community events; and

b. Is located in the community among other residential

buildings, private businesses, retail businesses, and

c. A community setting that offers opportunities for interaction with community members, and

d. Includes opportunities to learn about volunteer work in the community and referrals (resources and services) to prepare for, obtain and support volunteer work, and

e. Supports and facilitates social, recreational, skill-building, and community-based activities that do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

6. The Division shall not authorize Day Treatment services in the following settings.

a. A Community Residential Setting;

b. A contracted Intermediate Care Facility or

c. A Level I or Level II behavioral health facility;

d. In the same room at the same time as another service, except therapy services.

7. Responsibilities for Providers delivering Day Treatment services can be found in Provider Manual Chapter 2.

Signature of Chief Medical Officer: Anthony Dekker (May 26, 2023 13:45 PDT)

Anthony Dekker, D.O.

1240-F HOME DELIVERED MEALS

REVISION DATE: 08/30/23

EFFECTIVE DATE: August 09, 2023

REFERENCES: A.R.S. § 36-551; AMPM 1240-F

PURPOSE

This policy sets forth the Division of Developmental Disabilities (Division) guidance on Home Delivered Meals for ALTCS Members who live in their own home and are in jeopardy of not consuming adequate nutritious food to maintain good health.

DEFINITIONS

1. "Contactless Delivery" means once the package has reached its final destination, it is left outside the doorstep of the Member's home, or otherwise pre-designated location, without making any direct, in-person contact.
2. "Home and Community Based Services" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.
3. "Home Delivered Meals" means a service that provides a nutritious meal containing at least one third of the Federal

recommended daily allowance for the member, delivered to the member's own home.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Nutritionist" means an individual who has a bachelor's or master's degree in Food and Nutrition.

6. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

7. "Registered Dietician" means an individual who meets all the requirements for membership in the American Dietetic Association, has successfully completed the examination for registration and maintains the continuing education requirements.

8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. ASSESSMENT AND DOCUMENTATION

1. The Support Coordinator may assess for Home Delivered Meals for ALTCS Members who live in their own home.
2. The Support Coordinator shall document the Member's assessed need for this service, including the Member's ability to:
    a. Prepare their own meal or have a meal prepared by a caregiver,
    b. Store meals in their refrigerator and freezer, and
    c. Complete preparation of meals which require:
        i. Heating from frozen state, or
        ii. Addition of dried ingredients.
2. The Support Coordinator shall document when meals are needed by documenting in the services section, noting:
    a. The number of days; and
    b. The specific days per week.
3. The Support Coordinator shall not assess service levels:
    a. At a rate exceeding one meal per day,

b. For Members who receive Attendant Care Services (ATC) on the same days the Member receives ATC, unless the Support Coordinator:

i. Identifies and documents an extenuating circumstance which prevents the ATC staff from completing meal preparation tasks; and

ii. Receives approval to proceed with the service authorization.

B. ESTABLISHING SERVICE

1. The Support Coordinator shall coordinate with the Responsible Person to complete paperwork to initiate meal delivery with the vendor.
2. The Support Coordinator shall confirm the Member's following information is current:
   a. Phone number for Responsible Person, and
   b. Physical address where meals will be delivered.
3. The Support Coordinator shall offer the option of Contactless Delivery to the Member, reviewing:
   a. Advantages and disadvantages; and

b. Individualized considerations of the member's needs and preferences.

4. The Support Coordinator shall document a summary of the discussion regarding Contactless Delivery in the Member's file.

5. The Support Coordinator shall follow up with the Responsible Person within two days of submitting the request to the vendor to verify the vendor has made initial contact to begin services.

C. ONGOING

The Support Coordinator shall notify the service provider immediately if the Member:

a. Needs the service to temporarily stop,

b. Changes their address, or

c. No longer needs this service.

D. SUPPLEMENTAL INFORMATION

Up to a maximum of 14 days (two weeks) worth of meals will be delivered to the Member at one time. No new meals will be delivered prior to the time the next meal is expected.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:05 PDT)
Anthony Dekker, D.O.

1240-G SKILLED NURSING AND LICENSED HEALTH AIDE SERVICES

REVISION DATE: 1/10/2024, 09/14/2022, 6/9/2021, 7/3/2015, 9/15/2014
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: June 30,1994
REFERENCES: 42 C.F.R. 440.80, A.R.S. § 32-1601, A.R.S. §36- 2939, AMPM 1020, AMPM 1620-D, AMPM 1240-G, AMPM 1250-D, AMPM 310-I, AMPM 520.

PURPOSE

The purpose of this policy is to establish the requirements regarding medically necessary Home Nursing and Licensed Health Aide Services for Division Members who are eligible for Arizona Long Term Care System (ALTCS) services.

DEFINITIONS

1. "Activities of Daily Living" or "ADLs" means activities a Member shall perform daily for the Member's regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.

2. "H-NAT" means the Hourly Nursing Assessment Tool that is used to analyze and display the relationship between the Skilled

Nursing task and the necessary time to complete the task.

3. "Home" means the Member's place of residence, that is not a medical setting, which may include: a private home, group home, Adult Developmental Home (ADH), and a Child Development Home (CDH).

4. "Intermittent Nursing Services" means Skilled Nursing Services provided by either a Registered Nurse (RN) or Licensed Practical Nurse (LPN), for Visits of two hours or less in duration, up to a total of four hours per day.

5. "Inter-rater Reliability" or "IRR" means the process of ensuring that multiple observers are able to consistently define a situation or occurrence in the same manner, which is then recorded.

6. "Licensed Health Aide" or "LHA" means pursuant to A.R.S. § 32-1601, a person who is licensed to provide or assist in providing nursing-related services pursuant to A.R.S. § 36-2939 or:

   a. Is the parent, guardian, or family member of the Arizona

Long Term Care System (ALTCS) Member who is under 21 years of age and eligible to receive receiving Skilled Nursing or Skilled Nursing respite care services who may provide Licensed Health Aide (LHA) services only to that Member and only consistent with that Member's plan of care; and

b. Has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration, tracheostomy care, enteral care and therapy, and any other tasks approved by the State Board of Nursing in rule.

7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

9. "Pro Re Nata" or "PRN" means medications that are provided as needed and not on a regular basis.

10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

11. "Skilled Nursing Care" or "Skilled Nursing Services" means a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a Registered Nurse or a Licensed Practical Nurse).

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

13. "Visit" means one unit of LHA services. One unit is 15 minutes long. A Visit is usually two hours but may be greater or lesser

depending on the time it takes to render the procedure.

POLICY

A. SKILLED NURSING SERVICES

1. The Division shall cover medically necessary Skilled Nursing Services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the Member's Home.

2. The Division shall ensure that if the Skilled Nursing Services are furnished by an LPN, the services are:
   a. Provided under the supervision and direction of an RN or Physician, and
   b. Provided by a LPN that is employed by a Home Health Agency (HHA).

3. The Division shall provide Skilled Nursing Services as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of Intermittent Nursing Services and when the Division determines the services to be cost-effective.

4. The Division shall ensure that Skilled Nursing Services are provided by a:
   a. Medicare certified HHA; or
   b. State licensed HHA if a Medicare certified HHA is not available per AMPM 310-I.
5. Support Coordinators shall identify Members who potentially need Skilled Nursing Services through the Person Centered Service Plan and shall submit a referral to Health Care Services for an assessment by the District Nurse when skilled nursing needs are identified.
6. The District Nurse, upon receipt of the referral from the Support Coordinator, shall complete a nursing assessment, which contains:
   a. A review of the current medical files, including all pertinent health-related information, to identify potential health needs of the Member related to the Division nursing assessment and;

b. Assessment of the health status of the Member by a review of the current medical data, communication with the Member, team members and families, and assessment of the Member in relation to physical, developmental, and behavioral dimensions.

7. The District Nurse shall determine allocation of Skilled Nursing Care hours based on the nursing needs identified on the Division nursing assessment and the H-NAT.

8. The District Nurse shall complete each section of the H-NAT to evaluate the needs of the Member requiring Skilled Nursing Services.

9. The Division shall not cover Skilled Nursing Services for the sole purpose of helping with ADLs.

10. The Division shall cover ADLs when nursing providers assist Members while they are on duty and providing authorized Skilled Nursing Services.

11. When PRN Skilled Nursing Services are assessed, the District

Nurse shall describe in detail the medical need in the nursing assessment.

12. The District Nurse shall ensure that assessed services are provided to the Member within 14 calendar days for an existing ALTCS Member or 30 days for a newly enrolled ALTCS Member.

13. The Division shall ensure Skilled Nursing Services are ordered by a Physician.

14. The District Nurse shall ensure the HHA obtains an order from the Physician to perform duties related to Skilled Nursing Care if an order is not already in place.

15. The Division shall require the HHA to ensure that the Physician reviews and recertifies the plan of care at least every 60 days and that it is reviewed at every Person Centered Service Plan meeting.

16. The Division shall require the HHA to ensure that a Physician prescribes the services and the Skilled Nursing Services follow a written nursing plan of care developed by the Division contracted

Home Health provider, in conjunction with the Division's Support Coordinator, the Member or Responsible Person, and the District Nurse that includes:

a. Specific services to be provided,

b. Anticipated frequency and duration of each specific service;

c. Expected outcome of services;

d. Coordination of these services with other services being received or needed by the Member;

e. Input of the Member or Responsible Person; and

f. Assisting the Member in increasing independence.

17. District Nurses shall ensure care is delivered by the Member’s Skilled Nursing Service providers.

18. District Nurses shall conduct ongoing assessment and monitoring of the nursing needs and Skilled Nursing Services of each Member assigned to their caseload every 90 days.

19. The Support Coordinator shall invite the District Nurse to all Planning Team meetings if a Member is receiving Skilled Nursing Services, unless otherwise requested by the Responsible Person.

20. District Nurses shall work in collaboration with the Member's Planning Team to ensure that all Skilled Nursing needs are met and all services are medically necessary and cost-effective.

21. The District Nurse shall document any contact made on behalf of the Member related to Skilled Nursing Services in the Member's progress notes.

22. At least annually, the Division shall train District Nurses and nurse managers on the H-NAT.

23. At least annually, Nurse Managers will conduct IRR testing to ensure consistent application of review criteria in making medical necessity decisions.

B. LICENSED HEALTH AIDE (LHA)

1. The Division shall cover medically necessary LHA services in the

setting where the Member's normal life activities take place when provided by an HHA**.**

2. The Division shall provide LHA services as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of Intermittent Nursing Services and when determined to be cost-effective.

3. The Division shall require Visits include at least one of the following components:

   a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the Member;

   b. Monitoring and documenting of Member vital signs, as well as reporting results to the supervising RN or Physician;

   c. Providing Members with personal care;

   d. Assisting Members with bowel, bladder or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Administering, or assisting Members with self-administration of, medications;

f. Assisting Members with eating, if required, to maintain sufficient nutritional intake, and providing information about nutrition;

g. Assisting Members with routine ambulation, transfer, use of special appliances or prosthetic devices, range of motion activities or simple exercise programs;

h. Assisting Members in ADLs to increase Member independence;

i. Teaching Members and families how to perform home health tasks; and

j. Observing and reporting to the HHA Provider or the Support Coordinator of Members who exhibit the need for additional medical or psychosocial support, or a change in condition during the course of service delivery.

4. The District Nurse shall determine allocation of LHA services

based on the nursing needs identified on the Division nursing assessment and the H-NAT.

5. The District Nurse shall allocate LHA services in lieu of Skilled Nursing hours when skilled services fall within the scope of the LHA.

6. The Division shall ensure that Skilled Nursing Services, respite services provided by a RN or LPN, and LHA services are not provided concurrently.

7. The Division shall ensure that when LHA services are authorized for respite, the LHA is not the same individual for whom the respite is intended.

8. The Division shall ensure LHA services are provided under the supervision and direction of a RN or Physician.

9. The Division shall ensure the supervision of LHAs includes observing the LHA's competency in performing the necessary duties as required by the individual patient.

10. The Division shall ensure supervisory Visits occur within the

LHAs first week and:

a. Within the first 30 days,

b. Within the first 60 days, and

c. At least every 60 days thereafter.

11. The Division shall ensure that LHAs are employed by an HHA and licensed by the State Board of Nursing.

12. The Division shall ensure that LHA Services are provided through a Medicare Certified HHA.

13. The Division shall ensure that the Division rate book and claims manual reflect information on billing for LHA services.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:54 MST)
Anthony Dekker, D.O.

Exhibit 1240-G-1 Skilled Nursing Matrix

REVISION DATE: 9/14/2022, 1/31/2014
EFFECTIVE DATE: August 30, 2013

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Head To Toe Assessment	A comprehensive Nursing assessment that reviews all major body systems	A clinical assessment of all body systems for changes in condition.
Anticoagulant Therapy Including but not limited to injectable anticoagulant therapy	Medications used to make the blood less likely to clot or form scabs	Assessment and monitoring for unstable anticoagulant therapy
Apical Pulse Check Including but not limited to prior to giving heart medication	Use of a stethoscope to listen to the heart beat at the level of the apex of the heart	Listening to heartbeat on chest for a full minute to assess the heart rate, rhythm and volume.
Ventilator/Respirator, Diaphragmatic pacing	A machine that breathes for a person who is unable to breathe enough on their own	Monitoring vital signs, cardiopulmonary status, monitor airway, monitor for work of breathing, oxygen saturations,monitor equipment settings and functionality

Bi-level positive airway pressure (BiPAP); Continuous Positive Airway Pressure (CPAP)with a trach	A machine that helps an individual breathe and prevents the airway from collapsing and blocking the breathing in people with sleep apnea or other breathing problems	Turning on and off, changing settings, respiratory assessment, circuit changes
Blood Pressure Checks	Assessment of Blood Pressure	Blood pressure monitoring and treatment when it is too high or too low
Chest Percussion Therapy (CPT)	Therapy by clapping on the chest either manually or with a machine	Application of the therapy techniques and assessment of effectiveness, respiratory assessment
Complex wound care	Assessment and treatment of wounds	Assessment and treatment of wound, including but not limited to wound cleaning and bandage changes
Complex/Unstable Seizure Disorder	A change in the way a person acts or moves that is not normal due to a brain problem	Neurological assessment and emergency medical intervention for unstable seizure activity

Coughalator/cough assist device	A machine that causes the member to cough	Application of machine and assessment of effectiveness of machine; respiratory assessment
Dialysis (occurring at home), including Peritoneal dialysis or hemo dialysis	Cleaning of blood through a machine or tube	Assessment and monitoring; starting and stopping of the treatment
Extremity edema checks when ordered by a physician	Assessment of extra fluid buildup in the extremities	Checking for fluid in the legs or arms; assessment
GJ Tube Gastrostomy/ Jejunostomy Tube	A feeding tube into the gastric (stomach) continuing to the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Injections	Medication given with a needle	Administering medication with a needle
Insulin Administration	Medications given with a needle to treat diabetes	Administering insulin with a needle
Intermittent Partial Pressure Breathing (IPPB)	A machine to assist with breathing all the time	Monitoring effectiveness of machine, changing settings on machine as ordered, respiratory assessment and

		intervention, circuit changes
Intravenous (IV) Therapy (For individuals living at home)	Administration of fluids and medications into the venous blood supply	Administering medications through an IV into the blood and any dressing changes needed
Central Venous Access (CVA)	A thin flexible tube inserted into a vein and guided into a larger vein above the right side of the heart. It is used to give Intravenous fluids, chemotherapy, TPN, Lipids, and other medications.	Assessment of insertion site, patency of catheter and for complications. Administration of IV medications or blood draws per physician orders. Includes TPN/Lipid administration and IV line maintenance.
J-Tube (Jejunum-tube)	A feeding tube through the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Nasogastric enteral feeding (NG tube)	A plastic tube that is used to deliver formula and medicine to the stomach. It is inserted through the nose, passes the throat, and placed into the stomach.	Insertion and removal of NG Tube, Monitoring for NG Tube placement, skin assessment to the area's/sites that the NG Tube enters, or is secured, starting/stopping NG Tube feedings,

		monitoring nutritional status tolerance of tube feedings

Nephrostomy	Surgically placed tubes used to flush fluid to clean the kidney(s)	Flushing fluid into tubes that cleans the kidney(s)
Ostomy irrigation	Flushing of an opening into the body with fluid	Cleaning out the organ with fluid
Ostomy Care	Care and maintenance to the Ostomy site and changing the ostomy wafer and pouch	Assessment of skin condition and ostomy site, assessment for signs of complications to include gastrointestinal complications, tissue integrity complications and for complications of the ostomy/stoma site
Oxygen Titration	Giving oxygen at an amount that changes dependent on the person's blood oxygen level	Changing the level of oxygen administration based on pulse oximeter readings
Postural drainage	A treatment to clear the lungs by moving the body in a downward position	Assessment and draining the lungs of fluids
Pressure Ulcer	An area of the skin that breaks down when	Assessment and monitoring of the care

	something keeps rubbing or pressing against the skin	and healing of the pressure ulcer
Pulse Oximeter	A machine that measures oxygen levels in the blood	Monitoring the amount of oxygen in the body
Sleep Apnea	The temporary stoppage of breathing during sleep	BiPAP machine or Vent used to treat the condition, respiratory assessment (the assessment for Apneic episodes)
Small Volume Nebulizer (SVN) (varied or unscheduled)	Medications given at varied times using a small-volume nebulizer, a device that holds liquid medicine which is then turned into a fine mist	Assessment of needed time for medicated breathing treatments
Sputum sample	Chest fluid sample test	Collection of fluid from chest
Straight catheterization (does not include catheter care and maintenance)	Insertion of a single use catheter to drain the bladder	Assessment of placement, drainage and skin integrity. Monitoring of urinary output and education
Suctioning (tracheal or deep through the nose or mouth)	The insertion of a suction catheter into the throat, and/or lungs through the mouth, nose or a tracheostomy to remove secretions	Inserting tube into the throat and/or lungs through the mouth or the nose to get fluid out

	from the lungs/airway.	

Tracheotomy	A surgery to make and opening through the neck into the windpipe to allow for breathing	All tracheotomy management and care

1240-I HOME MODIFICATIONS

REVISION DATE: 3/2/2015
EFECTIVE DATE: June 30, 1994
REFERENCES: A.R S. §§ 41-1491.19.D.1 and 32-1101.01.

Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the member's specific needs. Terms often associated with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access, or universal design.

Members who are eligible for the Arizona Long Term Care System (ALTCS) are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home. Home modifications must be medically necessary, cost-effective, and reduce the risk of an increase in Home Community Based Services (HCBS) or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial, and measurable rehabilitative service for the member.

The Division must approve or deny requests for home modifications within 14 calendar days from the “identified need date.” A request that requires an additional extension for up to 14 days and is in the member’s best interest. Requires the member receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the member. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30 days. A certified staff person must conduct a home visit to make this assessment. The “identified need date” is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification, such as a curbless shower, "handrails,” or widen doors, the Support Coordinator via the Planning Document can make a request for that specific modification. The “identified need date” starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days, and is in the member’s best interest, requires the member receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad “contingent” recommendation if sufficient evidence is present to move forward with the request.

Scope of Home Modifications

The unit of service is one home modification project. Using the member’s primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home

modification for the person will include, but not be limited to, the following areas of the home:

A. Member's bedroom;

B. Most appropriate, cost-effective bathroom;

C. Most appropriate, cost-effective entrance/exit to the member's home, i.e., a ramp; and,

D. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the member lives alone.

The types of permanent installations for architectural barrier removal include:

A. Widening of doorways – entrance and exit to one bathroom and the member's bedroom;

B. Accessible routes to one bathroom and the member's bedroom;

C. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, as prescribed;

D. One wooden or concrete ramp/low inclined walkway; and,

E. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the member lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (e.g., curb-less showers) will consider the use of durable medical equipment (e.g., shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The member must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement, or home safety will be denied.
Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must

necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

New Construction

The service covers only modifications to existing structures of a member/family owned home where the person resides. Members/families that are planning for a new home are responsible for all the architectural access design/construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

Homes Not Owned by the Member (Rental/Lease)

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/member, documentation providing permission to allow for renovations on behalf of the member is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership, and address of residence requested for environmental access.

The Division will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the member has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy (www.azahcccs.gov/Regulations).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another member or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

Requirements for Medically Necessary Environmental Modifications

Requests for the environmental access to the person's home must include all of the following:

A. The need for environmental access documented in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan;

B. ALTCS Primary Care Provider order;

C. An assessment by a qualified professional, e.g., Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained;

D. An authorization by the Home Modifications Manager; and,

E. The evidence that the member resides in a private residence. Members residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

Procedures

When a member has recognized a need for home modifications, a request for a home modification begins by contacting the member's Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the "Initial Request for Home Visit" fax form upon receipt of a member's request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a Primary Care Provider (PCP) is another way to make this request. Requests for a home modification may also be made using a home assessment from a Physical/Occupational Therapist. At the time of request for home modifications the Support Coordinator shall enter into the case file via the "Individual Support Plan" or the "Change of Individual Support Plan" form, the need for an assessment to determine specific modifications.

The date recorded in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the "need identified" date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension for up to 14 days and is in the member's best interest, requires the member receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the member's case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a member's independence. The home visit will assess the relationship of the member's ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.
The home assessment will include:

A. Consideration for member's abilities and disabilities based upon aids to daily living;

B. Consideration of information that is obtained from the member, family or others in the household and members of the Planning Team;

C. Consideration of hazardous areas of the home based on physical and/or cognitive/intellectual disabilities;

D. Identification of the Planning Documents needs as they relate to delivering services to the member;

E. Identification of diagnosis-related modifications;

F. Provisions for necessary assistive devices and durable medical equipment;

G. Provisions for necessary architectural barrier removal; and,

H. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the member's Support Coordinator. This includes:

A. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division's Medical Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.

B. Obtaining the PCP order for the project using the prescription form approved by the AHCCCS at 15 days from the "need identified" date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.

C. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.

D. The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the member upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. *Note:* The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bids - (at least two (2) bids). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the member's residence.
Complete the *Environmental Modifications Request Form* to track progress of the project. Ensure that member's identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor, and District Program

Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the Lieutenant Program Manager/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

A. Environmental Modifications Request;

B. Member's Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access;

C. Professional assessment dated within time of request or review with signature from Division's Medical Director;

D. PCP order dated within time of request;

E. Project Specification Sheet and Floor plan (before and after, site plan); and,

F. Contractor bids.

Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater than $9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain Project Packet progress with in required time frames.

1240-J EMPLOYMENT SERVICES

EFFECTIVE DATE: April 21, 2023
REFERENCES: AMPM 1240-J

PURPOSE

This policy establishes the requirements for and describes covered employment services and support services for Division members enrolled in the Arizona Long Term Care Services (ALTCS) program.

DEFINITIONS

1. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an individual is:

    a. Compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience;

    b. Receiving the same level of benefits provided to other employees without disabilities in similar positions;

c. At a location where the employee interacts with other individuals without disabilities; and

d. Presented opportunities for advancement similar to other employees without disabilities in similar positions.

2. "Enclave" means a worksite of a competitive employer where a worker with a disability or group of workers with disabilities are working and supervised by staff from the qualified vendor. The workers remain on the qualified vendor's payroll and authorizations to pay subminimum wage is based on the work center's certificate.

3. "Mobile Work Crew" means a small crew of persons with disabilities that operates as a self-contained business that generates employment for their crew members by selling a service. The crew may work at several locations within the community, under the supervision of a job coach. This type of work may include janitorial, groundskeeping, or maintenance.

4. "Self Employment" means the following are met:

a. The person is directly involved in their own recognizable business, trade, or profession. This may include odd jobs or irregular and varied activities,

b. No employer-employee relationship exists and the person controls the hours worked and how the work is performed, or

c. The person works for someone else on a commission basis but pays their own federal taxes. In general, if taxes are deducted from the person's pay, the person is NOT self-employed.

POLICY

A. EMPLOYMENT FIRST

1. The Division shall participate as a partner in Arizona's Employment First initiative by:

   a. Providing services and supports to implement Employment First principles and practices, and

b. Coordinating efforts to improve employment opportunities for working-age adults.

2. The Division shall adopt the following principles and ensure service planning and service delivery aligns with these principles:

a. Employment shall be the first and expected outcome for all working-aged members.

b. Members shall have access to competitive integrated work settings.

3. The Division shall provide members with the following information to help them make informed decisions about employment.

a. Employment supports and services,

b. Knowledge about the value of employment on their quality of life,

c. Understanding of how work affects public benefits and resources so that employment remains an option without fear of losing essential benefits,

d. Focus on an individual's priorities, strengths, abilities, and interests, and

e. Appropriate supports and services such as supported and customized employment and assistive technology.

c. Long-term supports and services if needed to be successful in the workplace.

B. EMPLOYMENT SERVICES

1. The Division shall provide employment services and supports while applying this philosophy of empowerment and opportunity through the implementation of employment programs, measurement of outcomes, communication, and collaboration with all providers, subcontractors, and stakeholders.

2. The Division shall discuss employment with all members 14 years or older.

3. The Division shall provide a diverse range of employment services, from pre-employment services to post-employment supports, that are individualized to the member. The member's

employment services shall provide opportunities for them to participate in the range of pre-employment services based on their job goals, strengths, priorities, interests, and abilities.

4. The Division shall deliver pre-employment services, that shall be provided individually or in a group setting, to prepare members for engagement in meaningful work-related activities, such as volunteerism or services necessary to achieve full-or part-time competitive integrated employment, including self-employment. This may include the following:

   a. Vocational assessments to determine strengths, knowledge, skills, interests, and abilities,

   b. Career/educational counseling,

   c. Access to transportation training, including how to use public transportation and/or mobility training,

   d. Community trial work experiences, including volunteer work, career exploration, and job shadowing,

e. For Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) beneficiaries, benefits counseling on how working income may affect benefits,

f. Job training services, including vocational skill building and training related to soft skills necessary to be successful on the job,

g. Supervised supported employment in a group setting, including Enclaves and Mobile Work Crews,

h. Other training, including resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management, and

i. Assistance in job search.

C. PRE-EMPLOYMENT SERVICES

1. The Division shall assess and authorize Group Supported Employment when the member needs a service that shall provide the member with an on-site, supervised, paid work

environment in an integrated community setting.

2. The Division shall assess and authorize for Center Based Employment when the member needs a service:

   a. That shall provide the member with a controlled, protected, and supervised environment.

   b. That shall be provided in a Qualified Vendor-owned or leased setting.

   c. That shall provide the member with a goal to develop general, non-job-task-specific strengths and skills with a goal of integrated employment in the community including group and individual supported working environments

3. The Division shall assess and authorize Career Preparation and Readiness when the member needs assistance to obtain competitive and/or integrated employment.

   a. Members currently participating in Center Based Employment shall receive services and supports to assist them in making a progressive move into competitive

and/or integrated employment.

i. The Division shall assess and authorize Transition to Employment when the member needs a service that shall provide training in the meaning, value, and demands of work and in the development of positive attitudes toward work.

4. The Division shall assess and authorize for Employment Support Aide when the member needs additional supports to help them maintain successful employment. These supports may:
   a. Include personal care services, and behavioral intervention,
   b. Be provided in Group Supported Employment

D. POST EMPLOYMENT SERVICES

1. The Division shall assess and authorize for Individual Supported Employment when the member needs services to maintain, or obtain, employment and has exhausted services, services are not available, or is not eligible for services through Vocational Rehabilitation. The member shall receive the following services:

a. Job coaching at a competitive integrated job, or

b. Job search services

2. The Division shall assess and authorize for Employment Support Aide when the member needs additional supports to help them maintain successful employment. This support::

a. Includes “Job follow along” supports

b. May be provided with Individual Supported Employment

3. May be provided as a stand-alone service.

4. The Division shall ensure members are educated on the following:

a. Arizona Disability Benefits 101 (DB101), so that members:

i. Understand how disability benefits, such as SSI and SSDI, may change with working income and choose an employment goal based on that understanding, and

ii. May set up their own DB101 accounts and use it independently to make future employment decisions.

b. Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR), so that members understand:

i. RSA/VR, as the primary payer of employment services, must be offered to members interested in gaining employment,

ii. RSA/VR eligibility criteria,

iii. How the RSA/VR program can assist in their pursuit of becoming employed,

iv. The types of services RSA/VR may provide, and

v. Are able to make informed decisions about participation in the RSA/VR program and request a referral to RSA/VR when interested.

c. Community employment resources, including ARIZONA@WORK, so that members understand what is available in their community.

d. AHCCCS Freedom to Work (Medicaid Buy-In), so that members:

i. Understand it is affordable health insurance for individuals with disabilities who are employed, and

ii. Understand key concepts of the program, such as how to qualify, how to apply, what services are covered, and the cost of monthly premiums.

5. The Division may provide transportation services for eligible members when traveling to and from an employment service site. Employment service sites may be located at a Qualified Vendor site or at the location identified by the employer.

6. The Division shall ensure members receive employment services in an integrated community work setting. An integrated community work setting is a worksite that is located in a naturally occurring community of residential, business, social, or educational environments. Integrated work settings require that workers with disabilities shall have the choice and opportunity to:

a. Work alongside workers without disabilities, other than paid staff who are providing services to that individual,

b. Perform the same tasks with the same expectations that a non-disabled peer would perform for pay,

c. Freely participate in the social aspects common to the workplace, including but not limited to, having access to all common areas of the enterprise, eating lunch, and taking breaks together, and

d. With respect to facility-based services and these other standards for integrated work settings, members shall have the choice and opportunity to:

i. Develop products and services which are prepared in the facility but sold or provided out in the general community,

ii. Have alternate schedules for services and activities,

iii. Schedule activities at their own convenience,

iv. Have access to entrances and exits to the setting and any and all areas within the setting,

v. Engage in work and non-work activities that are specific to their skills, abilities, desires, needs, and preferences including engaging in activities with people of their own choosing and in areas of their own choosing (indoor and outdoor spaces), and

vi. Have access to food during breaks and lunch.

7. The Division shall ensure person-centered employment planning occurs with members interested in gaining or maintaining employment. Employment planning is, driven by the member, and the planning team, through informed choice, and shall include:

a. Members having an integrated employment goal (group or individual supported),

b. An annual readiness assessment is conducted for community-based employment and goals are developed to

address barriers when the member is not ready for the next step.

c. The duration of the service, as defined by the planning team,

d. Outline and prioritize the goals to be achieved,

e. DB101 and work incentive consultation to understand how working income may affect benefits, and

f. Opportunities for progressive moves.

8. The Division shall ensure members in facility-based, congregate employment programs prior to March 17, 2023, shall continue to receive those services without having a goal of working outside of the facility, however, providers shall continually assess and offer services geared toward these members obtaining a competitive job in the community.

9. The Division shall ensure members approved for facility-based, congregate employment programs after March 17, 2023 shall be

approved for no more than one year and reevaluated by the planning team at least one time annually.

10. The Division shall contract with a sufficient network of providers specializing in employment services covering all regions in the Geographical Service Area (GSA) and educate the providers on the importance and benefits of referring members interested in competitive integrated employment to RSA/VR.

11. The Division shall make all reasonable efforts to increase the number of providers who are mutually contracted with ADES/RSA for employment services.

12. The Division shall ensure any authorized attendant during the provision of pre- or post-employment services or at the employed member's workplace before and after work and/or during breaks is medically necessary. These services shall not substitute for the services or accommodations a member may be entitled pursuant to the Americans with Disabilities Act and/or the Rehabilitation Act of 1973 including reasonable accommodations rendered by an employer.

Signature of Chief Medical Officer: Anthony Dekker (Apr 20, 2023 11:52 PDT)

Anthony Dekker, D.O.

1250-D RESPITE

REVISION DATE: 12/18/2019, 7/15/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: Rate Book; AzEIP

Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Members who are cared for by Respite providers must be eligible for supports and services through the Division. Respite providers may be required to be available on a 24-hour basis. Respite services are intended to relieve caregivers temporarily. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for Respite services must be used for Respite services and cannot be transferred to another service.

Service Settings (Respite)

Respite may be provided in any of the following settings:

A. The member's home

B. A Medicare/Medicaid certified Nursing Facility

C. A Group Home, Foster Home or Adult Developmental Home certified by the Division

D. A certified Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID.)

E. A provider's home that complies with the requirements of the Department of Health Services or the Division.

Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

A. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the member.

B. The provider shall:

1. Supervise the member and meet their social, emotional, and physical needs.

2. Ensure the member receives all prescribed medications in the ordered dose and time.

3. Administer First Aid and give appropriate attention to injury or illness

4. Supply food to meet daily nutritional needs, including any prescribed therapeutic diets.

5. Furnish transportation as needed to day-programs and appointments.

6. Carry out any programs as requested by the Planning Team.

7. Report any unusual incidents to the Division in accordance with policies and procedures.

8. Ensure appropriate consideration of member needs, compatibility, and safety when caring for unrelated members.

Target Population (Respite)

Respite, as a medically related social service, is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also, appropriate based on the following factors:

A. The primary caregiver is unable to obtain Respite and other supports from his/her immediate/extended family or other community resources.

B. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.

C. A member with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.

D. The primary caregiver is experiencing an emergency that temporarily prevents the performance of normal responsibilities.

E. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.

F. The family is experiencing unusual stressors, such as care for more than one person who has a developmental disability.

Exclusions (Respite)

Exclusions to the provision of Respite services may include any of the following:

A. Respite shall not substitute for routine Transportation, daycare, or another specific service.

B. Respite shall not substitute for a residential placement.

C. Respite providers shall not serve more than three people at one time.

D. Child Developmental Homes and Adult Developmental Home providers shall not give services to more members than would exceed their Division license.

E. Child Developmental Homes and Adult Developmental Home Respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license. Additionally, the provider shall not offer services to adults if the license is for children and vice versa.

F. Respite is not available for members living in Group Homes or an ICF/IID.

G. Assisted Living Centers, non-state operated ICF/IID, Skilled Nursing Facilities;

Level I or Level II Behavioral Health Facilities, and members living independently are not approved for Respite.

Service Provision Guidelines (Respite)

A. The federal government and the Arizona Heath Care Cost Containment System (AHCCCS) set the upper limit of 600 hours per year regarding Respite services for members who are eligible for Arizona Long Term Care (ALTCS). Respite Service hours are determined on a yearly basis by the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.

B. Members who are eligible for Respite services funded by the state are subject to the availability of these funds. The continuation of Respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow primary care givers a break and, as such, the assessment for Respite hours will need to be reconciled with the amount of time a primary caregiver usually provides support.

C. All hours of Respite utilized by the member/family will be tracked and reported. Respite hours for members who are eligible for ALTCS will be reported to AHCCCS.

D. For Respite billing information see Department of Economic Security, Division of Developmental Disabilities Rate Book located on the Division's website at:

https://des.az.gov/services/disabilities/developmental-infant

E. A negotiated rate will be applied for families who have more than one person eligible for Respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each member on the Uniform Billing Document. This method of rate setting will be applied when these members receive Respite at the same time. The hours used will be deducted by the Division from the authorized level of Respite for each person.

F. Families receiving Respite for a member eligible for services from the Division who wish other non-eligible members to receive care will be responsible for the costs of serving the non-eligible member. The Division will only pay for services delivered to members authorized to receive such service and will pay the provider at a multiple client rate.

Provider Types and Requirements (Respite)

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of ALTCS services must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Respite)

The Support Coordinator must continually assess the quality of the services provided to members with developmental disabilities in accordance with the mission statement.

Additionally:

A. The provider shall submit attendance reports summarizing the members served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines.

B. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the on-going appropriateness of the service based upon the input from the providers and the member's caregiver(s).

Service Closure (Respite)

A. Respite shall terminate when the member begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Nursing Facility (NF).

B. Respite shall terminate when the family no longer desires the service.

C. Respite for members who are eligible for services through the ALTCS shall terminate when the maximum amount allowed has been used and there are no State funds available.

1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

REVISION DATE: 10/1/2021, 5/24/2021, 3/4/2020, 7/3/2015, 3/2/2015
EFFECTIVE DATE: June 30, 1994

Habilitative Therapy

Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in the respective documents.

Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical and Speech Therapy

Descriptions (Occupational, Physical and Speech)

Therapy services require a prescription for an evaluation and then a certified plan of care for ongoing therapy services, are provided or supervised by a licensed therapist, and are not intended to be long term services.

Occupational therapy may address the use of the body for daily activities such as dressing, sensory and oral motor development, movement, and eating.

Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

Speech therapy may address receptive and expressive language (pragmatic language, social communication), articulation, fluency, eating, and swallowing.

Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills;

B. Development of home programs and consultative oversight with the member, family and other providers;

C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety;

D. Modeling/teaching/coaching parents and/or caregivers' specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes; and,

E. Collaboration with all team members/professionals involved in the member's life.

Responsible Person's Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability

standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions; and,

B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills;

B. Medical conditions;

C. Member's network of support (e.g., family/caregivers, friends, providers);

D. Age; and,

E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy shall be provided in settings that support outcomes developed by the team. This includes:

A. The member's home;

B. Community settings;

C. Division funded settings such as day programs and residential settings for the purpose of training staff;

D. Daycare; and,

E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to the following:

Rehabilitative therapy (acute therapy) due to an accident, illness, medical procedure, or surgery. Rehabilitative therapy includes restoring former functions or skills due to an accident or surgery.

Funding for rehabilitative therapy shall be sought from:

1. Private/third party insurance;
2. Children's Rehabilitative Services (CRS);
3. American Indian Health Services (AIHS);
4. Comprehensive Health Plan (CHP);
5. Arizona Health Care Cost Containment System (AHCCCS); or,
6. Division of Disabilities (DDD)/Arizona Long Term Care Service (ALTCS) Acute

Health Care Plan.

F. Physical therapy is provided by the DD/ALTCS Acute Health Care Plan for members 21 years and older and will not exceed 15 visits for developmental/restorative, maintenance, and rehabilitative therapy for the benefit year.

G. Therapy for educational purposes.

Respiratory Therapy

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration. The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions; and,

B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider shall be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:

1. Conducting an assessment and/or review previous assessments, including the need for special equipment;

2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team;

3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member's treatment plan;

4. Monitoring and reassessing the member's needs on a regular basis;

5. Providing written reports to the Division staff, as requested;

6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff;

7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals;

8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment; and,

9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state- operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.

C. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

A. The physician determines that the service is no longer needed as documented on the "Plan of Care";

B. The member/responsible person declines the service;

C. The member moves out of State;

D. The member requires other services, such as home nursing; and,

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the member.

1250-Y SCHEDULED TRANSPORTATION

REVISION DATE: 2/7/2024, 7/15/2016, 7/3/2015, 9/15/2014
REVIEW DATE: 5/9/2023
EFFECTIVE DATE: June 30, 1994
REFERENCES: RFQVA DDD-2024

PURPOSE

The purpose of this policy is to outline the Division's requirements for covering Scheduled Transportation for ALTCS eligible Members to and from employment-related services, day services, and other Home and Community Based Services.

DEFINITIONS

1. "Community Residential Setting" means the same as A.R.S. § 36-551.

2. "Home and Community-based Services" or "HCBS" as defined in A.A.C. R6-6-1501, means one or more of the following services provided to Members:

    a. Attendant Care,
    b. Day Treatment and Training for Children or Adults,
    c. Habilitation,
    d. Home Health Aide,
    e. Home Health Nurse,

f. Hospice Care,
g. Housekeeping-Chore/Homemaker,
h. Non-Emergency Transportation,
i. Occupational Therapy,
j. Personal Care,
k. Physical Therapy,
l. Respiratory Therapy,
m. Respite services,
n. Speech/Hearing Therapy,
o. Supported Employment,
p. Other comparable services as approved by the AHCCCS Director.

3. "Member" means the same as "client" as defined in A.R.S. § 36-551.
4. "Scheduled Transportation" means regular, non-emergency, planned transportation provided to and from an HCBS service from a Qualified Vendor for an ALTCS-eligible Member.
5. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important

to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

6. "Planning Team" means means a defined group of individuals comprised of the Member, the responsible person if other than the Member, and, with the responsible person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.
7. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
8. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship

between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.

A. SCHEDULED TRANSPORTATION SERVICE REQUIREMENTS

1. The Division shall cover Scheduled Transportation when the Planning Team determines and documents in the Planning Document that the Member meets any of the following criteria:
    a. The Member is unable to provide their own transportation;
    b. The Member's natural supports cannot provide transportation; or
    c. The Member has no other community resources for transportation available.
2. The Division shall require the Planning Team to assess and document in the Planning Document the Member's needs associated with receiving Scheduled Transportation services, as applicable:
    a. Assistance with entering or exiting the vehicle;
    b. Supervision while waiting for transportation;
    c. Adaptations of the vehicle for accessibility;
    d. Accompaniment by an aide for health and safety; and

e. Special seating requirements if transported with other Members in the same vehicle.

3. The Division shall not cover Scheduled Transportation services if any of the following criteria apply to the Member:
   a. The transportation service is covered by the Member's health plan;
   b. The transportation service is school-related, covered by the local education agency, and documented in the Member's individual education plan;
   c. The Member is receiving habilitation services provided in Community Residential Settings;
   d. Transportation is included in the Home and Community Based (HCBS) service the Member is receiving; or
   e. The transportation is to a destination that is not to or from an HCBS service.
4. Network shall approve an extensive distance modified rate and a single person transport modified rate as outlined in the Division's rate book.

B. MONITORING AND SERVICE REVIEW REQUIREMENTS

1. The Planning Team shall review the Member's need for Scheduled Transportation services at each Planning Team meeting.
2. The Planning Team shall discontinue Scheduled Transportation services when:
   a. The Member no longer requires the service;
   b. The Scheduled Transportation meets the criteria in Section A.(3) of this policy; or
   c. Other transportation resources become available.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:19 MST)
Anthony Dekker, D.O.

1280 STATE FUNDED SERVICES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Member and Family Assistance

Member and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult members to live independently in their communities. Member and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

General Guidelines

All payments from these funds must be made to a vendor, not the family or member unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a member all exceptions must be prior approved in writing by a Lieutenant and Program Manager Services that may be purchased with Member and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. These services may include:

A. Automotive repairs (if the vehicle is unable to be driven and would put the member at risk if not repaired);

B. Clothing;

C. Corrective lenses;

D. Dental needs;

E. Diapers;

F. Equipment repairs;

G. Medication;

H. Moving expenses;

I. Rent and/or living subsidy;

J. Transportation; and,

K. Utilities.

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.

Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

A. Vendor name/place of business;

B. Date of purchase;

C. Description of item(s) purchased;

D. Name of Member; and,

E. Name of Support Coordinator.

All disbursements from Member and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within 30 days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a member with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for a member living in a vendor operated setting with prior written approval by the Lieutenant Program Manager for health and safety purposes.

One-time payment amounts typically should not exceed $500 per member or family. Any amounts over $300 require Lieutenant Program Manager approval.

Eligible Services

Only authorized services may be purchased with Member and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or member under Division contracts with service providers.

Emergency Support cannot be used to purchase services otherwise readily available to the family or members who are eligible for Arizona Long Term Care Service (ALTCS). Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere members who have failed to take all reasonable steps to enroll in the ALTCS program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Member and Family Assistance. These alternatives might include:

A. ALTCS;

B. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;

C. Food stamps, Arizona Supplemental Nutrition Program for Women, Infants & Children (WIC) and food banks;

D. Housing benefits available through Housing and Urban Development;

E. Vocational Rehabilitation Services and the Job Training Partnership Act Program;

F. Benefits rendered because of injury to persons or property;

G. Education programs;

H. Child support and adoption subsidies;

I. Arizona Health Care Cost Containment System (AHCCCS), Medicare, Indian Health Services and private health insurance; and,

J. Supplemental Payments Program and benefits furnished under the Older Americans Act.

Eligibility

All members/families must meet the following criteria to receive Emergency Support:

A. Enrolled in the Division service system.

B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for services.

C. Require funds for health or safety concerns for which no other funding is available.

Determination of Participation by Responsible Person

The Member and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is "needs-based" and is not tied to a specific income eligibility level unlike the ALTCS. Families must demonstrate their co-pay participation related to cost for the service, item, or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the member must be able to demonstrate how much income is devoted to shelter and food before Member and Family Assistance/Emergency support payment can be approved. The member must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The member's remaining resources are available for personal and incidental expenses. Members with more than $3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and member/responsible person shall complete the Member and Family Assistance Request Worksheet and Agreement when requesting participation in this program. The Planning Team shall review these documents and forward them, with a recommendation, to the District Program Manager/Lieutenant Program Manager or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the member or family.

Guidelines for Approving Emergency Support

The District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors in evaluating requests for Emergency Support:

A. Age and/or health status of the parents/family members;

B. Complexity of the member's needs the stress that these place on the family, and the family's ability to respond to that stress;

C. Degree of member or family participation in the cost of services relative to their means;

D. Degree to which the member is already receiving other Division funded services;

E. Availability of funding from all sources; and,

F. Reason for the emergent or extraordinary request.

The District Program Manager/Lieutenant Program Manager should respond to a request for Emergency Support within five (5) working days of the recommendation by the Planning Team.

Payments

Services are authorized and participation/co-payments identified on the Member and Family Assistance Worksheet and Agreement. If approved, the payment will go directly to the vendor identified by the member or family.

Waivers

The District Program Administrator/Lieutenant Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met.
The member, family, or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The Lieutenant Program Manager/ Program Manager will determine whether approval of the requested waiver will enable the goals and intent of the program to be met. The Lieutenant Program Manager/District Program Manager will respond to the initiator of the request, in writing, within ten working days. Payments to other than a vendor must also be approved by the Division's Business Operations Administrator.

Ongoing Support

Ongoing Support is an on-going payment to a vendor intended to support the family's effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the member or family or in the case of members living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities, and other living cost on behalf of a member.

When Ongoing Support payments are made to a provider for members living in an IDLA, the provider is required to maintain a detailed expenditures log for each member identifying all expenditures on behalf of the member, including:

A. Date;

B. Vendor;

C. Purchase/payment detail;

D. Amount; and,

E. Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.

Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Member and Family Assistance program and the Division.

Ineligible Services

Ongoing Support cannot be used for the following:

A. Services available under ALTCS;

B. Members who live in Developmental Homes, Group Homes, Intermediate Care Facilities for Persons with an Intellectual Disability, Nursing Facilities, or Assisted Living Centers;

C. Members who have failed to take all reasonable steps to enroll in the ALTCS; and,

D. Families with income that exceeds 300% of the federal poverty level.

Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan Team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

A. The ALTCS;

B. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance, and Emergency Assistance;

C. Food stamps, WIC, and food banks;

D. Housing benefits available through Housing and Urban Development and other housing assistance;

E. Vocational Rehabilitation Services and assistance through the Job Training Partnership Act;

F. Education programs;

G. Child support and adoption subsidy;

H. AHCCCS, Medicare, Indian Health Services, and private health insurance;

I. Supplemental Payment Program and benefits furnished under the Older Americans Act; and,

J. Other community, and religious based services, and programs.

Eligibility

All members/families must meet the following criteria during any month wherein Ongoing Support is received:

A. Enrolled in the Division;

B. Participation in the program by parent, other close relative, legal guardian, or by the member. This participation usually takes the form of a co-payment for goods or services, although it may involve participation in the form of a contribution of labor. Members in an IDLA with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

Determination of Participation by Responsible Person

Whenever possible, families or members must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The member must be able to demonstrate how much income is devoted to shelter, food, and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The member's remaining resources are available for personal and incidental expenses. Members with more than $1,500 cash or $2,000 in liquid assets are ineligible for Ongoing Support. The member's Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family's resources, and any funds the member may have:

A. Savings and checking accounts;

B. Bonds;

C. Trust funds;

D. Tort-feasor (civil judgments) funds;

E. Annuities;

F. Estates;

G. Wages;

H. Benefits;

I. Child support payments; and,

J. Other financial resources and income.

The Support Coordinator shall then submit the request, including the items or services to be purchased and amount of family or member participation.

Guidelines for Approving Ongoing Support

In evaluating requests for Ongoing Support, the District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors:

A. Availability of funding;

B. The likelihood that Ongoing Support will enhance the family's integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability;

C. The age and/or health status of the parents/family members;

D. The complexity of the member's needs, the stress that these place on the family and the family's ability to respond;

E. The degree of member or family participation in the cost of services relative to their means;

F. The anticipated duration of the need for service;

G. The degree to which the family/member is already receiving other Division funded services; and,

H. Other resources that may be available to the member/family.

The District Program Manager/Lieutenant Program Manager shall approve the response to a request for Ongoing Support funds within 14 working days of the recommendation by the Support Coordinator and Planning Team.

Payments

Authorized services, vendor payments and co-payments are identified on the Member and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient member or family, or upon receipt of a bill, rental agreement, invoice, or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.
Ongoing supports for food for members living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized amount will not result in an increase in the

subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

Waivers

Waivers of any Ongoing Support procedures, including member or family participation requirements, may be granted by the District Program Manager/Lieutenant Program Manager, if the goals and intent of the program are otherwise met.

The member, Support Coordinator, or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/Lieutenant Program Manager will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/Lieutenant Program Manager will respond to the initiator of the request, in writing within ten working of receipt of the request.

1290 BEHAVIORAL HEALTH ADVOCACY

EFFECTIVE DATE: July 19, 2023

REFERENCES: Behavioral Health Advocate Referral form (DDD-2093A), Behavioral Health Advocacy Plan (DDD-2092A).

PURPOSE

This policy sets forth guidance on how the Division of Developmental Disabilities (Division) the Division provides support to members who experience unique challenges of navigating systems of care while experiencing behavioral health challenges. This policy outlines when and how referrals are made to an Adult or Child Behavioral Health Advocate, explains the development of a Behavioral Health Advocacy Plan.

DEFINITIONS

1. “Behavioral Health (BH) Advocate” means for the purpose of this policy a Division staff member whose role is to offer independent support to members and families who feel they are not being heard, ensuring they are taken seriously, and that their rights are respected.

2. “Human Rights Advocates” means for the purpose of this policy, AHCCCS staff who assist and advocate on behalf of members determined to have a Serious Mental Illness with Service Planning, Inpatient Discharge Planning, and resolving appeals and grievances. Staff in this position are hired, trained, supervised, and coordinated through the AHCCCS Office of Human Rights-Special Assistance.

3. “Member” means an individual who is receiving services from the Division of Developmental Disabilities (Division).

4. “Responsible Person” means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

5. “Special Assistance” means the support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to

cognitive or intellectual impairment and/or medical condition. Special Assistance is offered through the AHCCCS Office of Human Rights.

6. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. ROLE OF A BH ADVOCATE

1. BH Advocates shall not represent their own views but amplify that of the person they are supporting.

2. BH Advocates shall offer support and guidance to assist members and their families to be empowered by having their voices heard and sharing in decisions regarding their health.

3. BH Advocates may work with a member for a short period of time to learn how to better advocate for themselves and navigate the Behavioral Health System. The BH Advocate has a non-adversarial role to support members and families to advocate for themselves through collaboration with system partners.

4. BH Advocates shall not perform the day-to-day duties of the Support Coordinator or the Behavioral Health Complex Care Specialist, however, the BH Advocates work closely with the Support Coordinator and the Planning Team to ensure the voice and expressed choices of the Member or Responsible Person is being heard, and barriers are being resolved so member's behavioral health needs are met.

B. REFERRALS FOR A BEHAVIORAL HEALTH ADVOCATE

1. The Support Coordinator shall review the need for a BH Advocate at the Planning Meeting for Division members of all eligibility types.

   a. The Support Coordinator shall attempt to advocate on behalf of the member and resolve a member's behavioral health care needs with the Division's function areas, the Health Plan, and providers before submitting a BH Advocate referral.

   b. Referrals for BH Advocates shall be made within three business days of an identified need for an Advocate.

2. The Support Coordinator or designee shall make a referral for a BH Advocate when:

   a. A member is exhibiting symptoms of a possible behavioral health disorder and may be in need of behavioral health services, or

   b. A member is diagnosed with a behavioral health disorder and the member or Responsible Person is willing to accept the assistance from an Advocate.

   c. Additionally, one of the following circumstances shall exist that impact the member's ability to receive needed care. The member or responsible person:

      i. Feels their voice is not being heard or their choice is not being respected regarding their behavioral health service needs.

      ii. Feels they are not actively involved in the service planning process.

      iii. Has limitations in the ability to communicate their

behavioral health needs.

iv. Is unable or does not know how to advocate for themself and would benefit from advocacy services.

v. May need assistance in navigating the behavioral health or other service systems of care.

vi. May need assistance in understanding the behavioral health grievance process.

3. The Division shall accept a request from a Responsible Person for a BH Advocate through:

a. Contacting the Member's Support Coordinator; or

b. Calling the Customer Service Center.

4. The Support Coordinator shall not make a referral for a BH Advocate through the Division's Office of Individual and Family Affairs (OIFA) when a member is assigned a BH Human Rights Advocate through the AHCCCS Office of Human Rights-Special Assistance, however, the BH Human Rights Advocate through the AHCCCS Office of Human Rights-Special Assistance may request to collaborate with a BH Advocate through the Division to assist

with meeting the member's needs.

5. The Support Coordinator may make a referral if a member has a guardian, and the guardian is willing to accept assistance from an Advocate.

C. BH ADVOCATE ASSIGNMENT

1. Division staff from other functional areas such as the Behavioral Health Administration, Nursing, OIFA, Support Coordination, or State Operations shall discuss an identified need for a BH Advocate with the Support Coordinator.

2. The BH Advocacy Supervisor shall request additional information if needed, to determine if a BH Advocate shall be assigned.

3. A BH Advocate shall contact the Responsible Person upon approval, to discuss the need for advocacy if the member is approved to receive a BH Advocate.

4. The Support Coordinator may request the OIFA Administrator to review the BH Advocate referral if a Member was denied a BH Advocate.

D. BEHAVIORAL HEALTH ADVOCACY PLAN

1. The BH Advocate shall contact the responsible person within three business days of approval for a BH Advocate, to discuss the Member's need for this support, and begin working on developing the Advocacy Plan by:

    a. Reviewing:

        i. Reasons for the BH Advocate request outlined in the referral, and

        ii. The Member's BH goals outlined in the Planning Document.

    b. Discussing with the Responsible Person the reason for the BH Advocate referral and goal(s) to be accomplished working towards ensuring the member's behavioral health needs are met.

    c. Developing action plan tasks, including:

        i. Persons involved with actions taken,

        ii. Targeted dates for task completion, and

iii. Dates of meetings the BH Advocate shall attend with the Member.

d. Discussing a targeted goal(s) for when BH Advocacy is no longer needed.

E. SUPPLEMENTAL INFORMATION

1. BH Advocate Roles and Responsibilities:

a. The BH Advocate shall contact the BH Complex Care Specialist, if one is assigned, to state the purpose of the BH Advocate involvement and to gather pertinent historical information.

b. Build relationships and knowledge of community resources in order to:

i. Support the member, and their family if applicable, to obtain and maintain needed services, including but not limited to Peer and Family Support Services when appropriate.

ii. Increase awareness of community resources for

children and adults and promote recovery, resilience, and wellness.

iii. Identify opportunities to inform and connect those seeking assistance to access programs and services to meet identified needs.

2. Support Coordinator Roles and Responsibilities:

a. Advocate for the member and continue to maintain the role of the member's primary case manager.

b. Identify when a member could benefit from a BH Advocate and inform the member how an Advocate can provide support.

c. Invite the BH Advocate to the Planning Meetings.

d. Maintain communication of any substantial changes that would impact the advocacy plan with the BH Advocate.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:04 PDT)
Anthony Dekker, D.O.

Exhibit 1240A-1 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 17 AND UNDER

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to meet medical necessity for **general supervision** for children age 17 and under as part of the Attendant Care service.

Age 17 and under: A child must meet the criteria indicated in one of the four categories outlined below:

A. Unsafe Behaviors

1. Documentation of behaviors placing the child at risk of injury to self or others; **AND,**

2. Documentation that the child is receiving or pursuing services through a behavioral health agency/professional; **or**,

3. Documentation of behaviors placing the child at risk of injury to self or others; **AND,**

4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the child at risk if left alone.

C. Confused/Disoriented

Documentation indicating a loss of skills (e.g., due to accident or injury) that are unlikely to be regained.

D. Wandering risk (age 13 - 17 only)

1. Documentation of the child leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; **AND,**

2. The youth is at risk to self or others when alone in the community or may be unable to return safely.

When a child age 17 and under meets one of the criteria outlined above, **general supervision** is then based on age criteria. The requirements outlined below may be waived with District Program Manager approval.

For children age 12 and under, general supervision may be provided when **all** of the following are met:

A. The child cannot attend a typical day care center because

1. The child's health and safety would be at risk; **OR,**

2. The health and safety of others will be at risk; **OR,**

3. A fundamental alteration of a day care center would be required. This requires documentation from the day care center;

AND,

B. Child care in a private home or a before/after school program offered by the school/local city or county is not available or cannot meet the child's needs;

AND,

C. The parent, guardian, or other adult is not in the home;

AND,

D. Division funded summer or after school program is not available or cannot meet the child's needs (Only applies to age 3 and above.)

For children age 13- 17 **general supervision** may be provided when **all** of the following are met:

A. A Division funded program is not available or has been considered and is not appropriate;

AND,

B. The youth receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP);

AND,

C. The parent, guardian or other adult is not in the home;

AND,

D. The youth has received, is receiving or will receive Habilitation to minimize the need for supervision in the future, if a wandering risk or has unsafe behaviors.

Exhibit 1240A-2 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 18 AND ABOVE

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to qualify for general supervision for adults age 18 and above as part of the Attendant Care service.

Age 18 and above: An adult must meet one of the criteria outlined below:

A. Unsafe behaviors

1. Documentation that behaviors place the adult at risk of injury to self or others; and,

2. Documentation that the person is receiving or pursuing services through a behavioral health agency/professional;

3. Documentation that behaviors placing the adult at risk of injury to self or others; or

4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the adult at risk if left alone.

C. Wandering risk

1. Documentation of the adult leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; and,

2. The adult is at risk when alone in the community and may be unable to return safely.

D. Confused/disoriented

1. Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia); or,

2. Documentation indicating a loss of skills (e.g., due to accident or injury) and are unlikely to be regained.

E. Unable to call for help even with a lifeline.

Documentation is available in the member's file that the adult is unable to use a telephone or press a button to alert the lifeline system.

When an adult 18 years of age and older meets one of the criteria outlined above, supervision is then based on the following age criteria. The requirements outlined below may be waived with District Program Manager approval.

For adults age 18 and above supervision may be provided when the first criteria and the others (if applicable) are met:

A. A Division funded employment/day program is not available or has been considered and not appropriate.

B. If still in school, the adult must receive enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).

C. If appropriate, an adult who has an identified wandering risk or has unsafe behaviors must have received, is receiving or will receive habilitation to minimize the need for supervision in the future.

Exhibit 1240A-3 ATTENDANT CARE SUPERVISION DOCUMENTATION REQUIREMENTS

REVISION: 2/26/2016
EFFECTIVE DATE: March 1, 2014

Overview

Documents that may provide justification of medical necessity for supervision include, but are not limited to the following:

A. Individual Support Plan;

B. Individualized Education Program (IEP);

C. Multi-Disciplinary Education Team (MET);

D. Medical Documentation;

E. Psychiatric/Psychological Evaluation;

F. Clinical Notes;

G. Incident Reports;

H. Pre-Admission Screening (PAS);

I. Police Reports;

J. Inventory for Client and Agency Planning (ICAP); and,

K. Adaptive Mini-Mental (Pre-Dementia Screening Tool).

1301 AGENCY WITH CHOICE

EFFECTIVE DATE: January 25, 2023

REFERENCES: AMPM Policy 1310-A

PURPOSE

The purpose of this policy is to outline requirements for the Agency with Choice (AWC) Member-directed service delivery model option as specified in A.A.C. R9-28-509. This policy applies to Members who have selected the AWC model and the Division staff supporting the Members.

DEFINITIONS

1. "Agency with Choice (AWC)" means a Member-directed service delivery model option offered to ALTCS Members who reside in their own home. Under the AWC option, the provider agency and the Member/IR enter into a partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker (DCW) and the Member/IR serves as the day-to-day managing employer of the DCW.
2. "Direct Care Worker (DCW)" means an individual who assists elderly individuals or individuals with a disability with activities necessary to allow them to reside in their home. A DCW, also

known as Direct Support Professional (DSP), is employed/contracted by DCW Agencies or, in the case of Member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

3. "Direct Care Worker (DCW) Agency" means an agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care, Homemaker or Habilitation.
4. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
5. "Individual Representative (IR)" means, for AWC only, a parent, family member, guardian, advocate, or other individual authorized by the individual to serve as a representative in connection with the provision of services and supports, as specified in A.A.C. R9-28-509.

a. If a Member is unable to fulfill the co-employment roles and responsibilities on their own, an IR may be appointed to assist the Member in directing their care.

b. The role of an IR is to act on the Member's behalf in choosing and directing care, including representing the Member during the service planning process and approving the service plan.

c. A.A.C. R9-28-509 and Section 1915(k) of the Social Security Act, prohibit an IR from serving as a Member's paid DCW.

6. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

7. "Service Plan" or "Person Centered Service Plan (PCSP)" means a complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities and strategies to assist the Member in achieving an improved quality of life.

8. "Support Coordinator" means the same as "Case Manager" under

A.R.S. § 36-551.

POLICY

A. MEMBER'S ROLES AND RESPONSIBILITIES UNDER AGENCY WITH CHOICE

1. Members shall make decisions about who will provide their services, when those services will be provided, and how the services will be provided when selecting the Agency with Choice (AWC) model.
2. The Member and the provider agency shall share employment/day-to-day management, roles, and responsibilities of the DCW.
3. Members may opt in and out of the AWC at any time by notifying the provider agency and their Support Coordinator.
4. At a minimum, the Member shall have two responsibilities which they shall carry out, if necessary:
    a. Recruiting and selecting the DCW(s). This includes:
        i. Identifying the qualifications, skills, and characteristics of a DCW, over and above the minimum AHCCCS and provider agency

qualifications, that are necessary to meet the individual Member's needs, and

ii. Selecting the DCW from a pool of DCWs already employed by the provider agency or recruiting the DCW from the community to become an employee of the provider agency.

b. Dismissal of the DCW(s). This includes:

i. Identifying whether or not the Member is satisfied with the care provided by the DCW, and

ii. Making the decision to dismiss the DCW from providing their care only.

5. The Member may choose to carry out some or all of the following additional responsibilities:

a. Training the DCW(s), and

b. Identifying training needs, over and above the minimum required training by AHCCCS or the provider agency, that are necessary to meet their unique needs.

6. The Member shall manage the DCW(s) by:

a. Orienting the DCW to the manner in which they want the services provided;

b. Determining the schedule for the DCW, including the days/times when the specific tasks will be done; and

c. Verifying the dates and times the DCW provides the service.

7. The Member shall supervise the DCW(s) by:

a. Providing oversight and instruction to the DCW to ensure they are receiving quality care,

b. Communicating regularly with the provider agency about the DCW's performance, and

c. Providing feedback to the DCW regarding their performance.

8. The Member shall communicate with the provider agency regarding changes in service delivery by:

a. Notifying the provider agency when the DCW does not show up or cannot provide services that day, and

b. Notifying the provider agency when a service scheduling change has occurred.

B. SUPPORT COORDINATOR'S ROLES AND RESPONSIBILITIES

In addition to the Support Coordinator Standards specified in AMPM Chapter 1600, the Support Coordinator shall be responsible for the following for Members electing AWC:

1. Informing and educating Members about the AWC option including verifying that Members electing AWC understand required and optional roles and responsibilities;
2. Supporting the Member to assess whether or not they desire or need an IR to assist them in directing their care. The Support Coordinator shall use AMPM Policy 1310, Attachment B, to document the name and relationship of the IR to the Member and their respective roles and responsibilities;
3. Supporting the Member to recruit and select the DCW(s):
    a. Presenting options to the Member for recruiting and selecting the DCW(s):
        i. Selecting the DCW from a pool of DCWs already employed by the provider agency, and
        ii. Recruiting the DCW from the community to become an employee of the provider agency.

b. Assisting the Member in identifying qualifications, skills, and characteristics of a DCW that are necessary to meet their needs;

c. Assisting the Member in identifying how many DCW(s) they might need to provide their care;

d. Assisting the Member in identifying and initiating contact with a provider agency.

4. Supporting the Member to dismiss DCW(s):

a. Assisting the Member in utilizing conflict resolution strategies with the DCW and the provider agency in the event they are unsatisfied with the DCW(s) or the provider agency's performance, and

b. Assisting the Member to develop a transition plan to ensure there are no interruptions in the provision of care.

5. Supporting the Member, as needed, to receive training regarding their roles and responsibilities:

a. Assisting the Member in identifying whether or not they need training to fulfill their roles and responsibilities, and

b. Finding a provider to conduct the training and authorize the service.

6. Supporting the Member to train DCW(s):
   a. Assisting the Member in identifying whether or not additional training is required for the DCW in order to meet Member specific needs,
   b. Ensuring the requested training is within the service scope specifications for DCW training as specified in this policy, and
   c. Finding a provider to conduct the training and authorize the service.
7. Supporting the Member to manage DCW(s):
   a. Ensuring care provided is within the scope of services and the service hours authorized and specified in the Service Plan; and
   b. Ensuring Members understand what services need to be provided on a specific basis, versus services that are more flexible with regard to when they are provided.
8. Supporting the Member to supervise DCW(s):

a. Encouraging Members to communicate directly with the DCW and the provider agency particularly when it pertains to DCW's performance and/or quality of care concerns, and

b. Following up with Members to inquire about their progress in implementing AWC.

9. Obtaining and maintaining a current copy of AMPM Policy 1310-A, Attachment A, supplied by the DCWs.

C. PROVIDER AGENCY ROLES AND RESPONSIBILITIES

The roles and responsibilities of Provider Agencies shall be as outlined in Provider Policy Manual, Chapter 46.

SUPPLEMENTAL INFORMATION

AWC is a Member-directed option that allows Members to have more control over how certain services are provided, including services such as attendant care, personal care, homemaker, and habilitation. The Member-directed options are not a service, but rather define the way in which services are delivered and are available to ALTCS members who live in their own home. The options are not available to Members who live in an alternative residential setting or nursing facility. Member independence and personal choice are the primary objectives of the AWC Member directed option.

Members choosing to participate in the AWC Member-directed option shall be interested in actively taking responsibility for managing their own health care. Throughout the Policy, the term “Member” means the Member or the Member’s IR. Member-directed options represent a philosophical approach to service delivery that maximizes a Member’s ability to:

1. Identify their own needs.
2. Determine how and by whom their needs are met:
    a. Choose which tasks to receive from their DCW or ACW within the scope of the Service Plan;
    b. Select the days and times for service delivery; and
    c. Recruit, hire (select), manage, supervise, and terminate (dismiss) the DCW of his/her choice, including family members. Parents of minor children are prohibited from serving as a paid DCW.
3. Define what constitutes quality of care in the delivery of their services. ALTCS members can direct care for one or more services under the AWC option including, Attendant Care, Personal Care, Homemaker, and Habilitation (in-home/day). The DCWs serving Members under the AWC option shall be

employees of the Provider Agency, in order to fulfill the legal employer roles and responsibilities in partnership with the Member's managing day-to-day employer roles and responsibilities. If a Member is unable to fulfill the roles and responsibilities as specified in AMPM 1310-A, Attachment A, for the above listed services on their own, an IR may be appointed to assist the Member in directing their care. If a Member has a guardian, that guardian automatically serves in the capacity of an IR. The role of an IR is to act on the Member's behalf in choosing and directing care, including representing the Member during the service planning process and approving the Service Plan. A.A.C. R9-28-509 and Section 1915 (k) of the Social Security Act prohibit an IR from serving as a Member's paid DCW. The number and frequency of authorized services are determined through an assessment of the Member's needs by the Support Coordinator with the Member and/or the Member's family, health care decision maker, and their designated representative, in tandem with the completion of the cost-effectiveness study. Refer to the FFS Provider Billing Manual

for information regarding service codes and modifiers. Members are not precluded from receiving other medically necessary services. Refer to AMPM Policy 1240-A for more detailed information about the services ALTCS members can direct under AWC. Within AWC the Member, the provider agency, and the Support Coordinator are critical to the effective implementation of the Member's Service Plan. Each of these individuals has roles and responsibilities which shall be met in order for the Service Plan to be successful.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:47 MST)
Anthony Dekker, D.O.

1302 INDEPENDENT PROVIDER PROGRAM

EFFECTIVE DATE: November 9, 2022

PURPOSE

The purpose of this policy is to outline requirements for the Division's Independent Provider Program.

DEFINITIONS

1. "Direct Care Worker (DCW)" means an individual who assists elderly individuals or individuals with a disability with activities necessary to allow them to reside in their home.
2. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
3. "Employer of Record" means the responsible person enrolled with the Fiscal Intermediary services as the employer.
4. "Fiscal Intermediary" means a contracted provider that files state and federal paperwork required for a member to serve as the

employer and required for an Independent Provider to be an employee of the member and that provides payroll functions.

5. "Individual Independent Provider" means an individual who has a service agreement with the Division to provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP), or Habilitation (HAH/HAI) and who is a DCW.

POLICY

A. The Division shall offer members and their families the ability to direct their care and give the member control over assigning duties and schedules for the Direct Care Worker including hiring, firing, and some training requirements through the Independent Provider Program.

B. An Individual Independent Provider shall not provide more than 40 hours per week in combination of all services to all members.

C. An Individual Independent Provider shall adhere to the Division's Provider Manual.

D. The Division shall allow the member or responsible person to change Individual Independent Providers at any time.

E. The member or responsible person shall:

1. Identify any training needs, over and above the minimum required training by the Division, that are necessary to meet their unique needs.
2. Select the Individual Independent Provider from a pool of Individual Independent Providers already contracted by the Division.
3. Orient the Individual Independent Providers to the manner in which they want the services provided.
4. Provide feedback to the Individual Independent Provider regarding the performance and dismiss or fire if the member is not satisfied with the care provided.
5. Provide oversight and instruction to the Individual Independent Provider to ensure they are receiving quality care.
6. Communicate regularly with the Support Coordinator about the Individual Independent Provider performance.
7. Enroll with the Division's Fiscal Intermediary agency as the Employer of Record and verify service visits using the fiscal intermediary's EVV system.

F. The Fiscal Intermediary shall:

1. Maintain an EVV system as required by AHCCCS.
2. Process payments to Individual Independent Providers.
3. Manage required withholdings.
4. Provide tax documentation of members and providers.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 12:25 PDT)

Anthony Dekker, D.O.

1400 RESERVED

1500 RESERVED

1601 ASSIGNMENT OF SUPPORT COORDINATORS

REVISION DATE: 8/9/2023, 4/17/2015

EFFECTIVE DATE: January 15, 1996

REFERENCES: AMPM 1630

PURPOSE

The purpose of this policy is to set forth the Division of Developmental Disabilities (Division) guidance on assigning a Support Coordinator to each Division Member.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
3. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. ASSIGNMENT

1. The Division shall assign a Support Coordinator to each person eligible for Division membership.
2. Support Coordination Supervisors shall assign Support Coordinators to Members based on the Support Coordinator's current:
   a. Complexity of caseload, and
   b. Availability.
3. The Division shall honor the Responsible Person’s choice of Support Coordinator to the best of the ability of the District in which the Member lives.
4. The Division shall honor the Responsible Person’s request to be placed on a pending list for their first choice of Support Coordinator.
   a. If the Responsible Person chooses placement on a pending list, another Support Coordinator shall be assigned in the interim.

b. Support Coordinator Supervisors shall ensure the Responsible Person is assigned to the Support Coordinator of choice whenever possible.

5. The Division shall assign a Support Coordinator for Member's in the care of the Arizona Department of Child Safety in the District where the Member physically resides.

B. BACK-UP SUPPORT COORDINATOR

1. The Division shall designate a back-up Support Coordinator for each person eligible for the Division.
   a. Division staff shall refer a Responsible Person immediately to the Back-Up Support Coordinator, when the Responsible Person contacts an office and the assigned Support Coordinator is not available.
   b. The Support Coordination Supervisor shall act as the back-up Support Coordinator in instances where a back-up Support Coordinator is not available.
2. The Division shall notify the Responsible Person in writing and in advance when there is a change in Support Coordinator, whenever possible.

C. CASELOAD MANAGEMENT

1. The Division shall monitor caseload ratios at the Division district statewide level to ensure the average caseload size does not exceed the ratio standards set forth by AHCCCS.
   a. The Division shall request exceptions from AHCCCS' Division of Health Care Management, prior to implementing caseloads which exceed this ratio.
   b. The Division may establish caseloads at a lower ratio without prior approval from AHCCCS.

Signature of Chief Medical officer: Anthony Dekker (Aug 2, 2023 13:31 PDT)
Anthony Dekker, D.O.

1610 GUIDING PRINCIPLES AND COMPONENTS OF SUPPORT COORDINATION

REVISION DATE: 4/10/24, 7/6/2021
REVIEW DATE: 11/13/2023
EFFECTIVE DATE: July 31, 1993
REFERENCES: AMPM 1610

PURPOSE

This policy establishes an overview of the guiding principles and components of Support Coordination.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
3. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family

members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551
5. "Support Coordination" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. GUIDING PRINCIPLES

1. The Division shall manage and deliver services and supports to Members in a manner which is consistent with the following guiding principles:
   a. Member-Centered Services
      i. The Member is the primary focus.
      ii. The Member and Responsible Person, if other than the Member, are active participants in the planning, identification and evaluation of physical, behavioral,

and long-term services and supports.

iii. Services are mutually selected through person-centered planning to assist the Member in attaining their goal(s) for achieving or maintaining the Member's highest level of self-sufficiency.

iv. Up-to date information about the Arizona Long Term Care System (ALTCS)-DD program, choices of options and a mix of services is readily available to Members and presented in a manner that facilitates the Member's ability to understand the information.

b. Employment First Philosophy:

i. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.

ii. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

iii. Employment First supports an overarching goal that eligible individuals with disabilities will have access

to integrated work settings most appropriate for them, including the support necessary to help them succeed in the workplace.

iv. Employment First does not mean employment only and does not deny individual choice.

v. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.

c. Member-Directed Options

i. Members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making informed decisions about how best to have their needs met including who will provide the service and when and how the services will be provided.

d. Person-Centered Planning

i. Person-centered planning maximizes Member-direction, and supports the Member in making informed decisions, so that the Member can lead or participate in the process to the fullest extent

possible.

ii. The Planning Document developed through this process, safeguards against unjustified restrictions of Member rights and ensures Members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible.

iii. The Member's DDD Support Coordinator, in collaboration and coordination with the DDD Health Plans, ensures responsiveness to the Member's needs and choices regarding service delivery, personal goals, and preferences.

e. Consistency of Services and Supports

i. An accessible and consistently available network of services and supports is developed to ensure the delivery, quality, and continuity of services.

ii. Services and supports are provided in accordance with the Planning Document as agreed to by the Responsible Person and as authorized by the Division, consistent with coverage responsibility.

f. Accessibility of Network

i. Network sufficiency supports choice in individualized Member care and availability of services.

ii. Provider networks are developed to meet the unique needs of Members with a focus on accessibility of services for Members with disabilities, cultural preferences, and individual health care needs.

iii. Services are available to Members to the same extent that services are available to individuals who are not receiving services through the Medicaid system.

g. Most Integrated Setting

i. Members live in the most integrated and least restrictive setting and have full access to the benefits of community living.

ii. Members are afforded the choice of living in their own home or choosing an alternative Home and Community Based Setting (HCBS) rather than residing in an institution.

iii. Members receive comprehensive services in the most

integrated and least restrictive setting, allowing them to be fully integrated into their communities.

iv. Members are afforded the choice to receive HCBS in community settings where individuals who do not have disabilities spend their time.

h. Collaboration with Stakeholders

i. Ongoing collaboration with Members, the Responsible Person, if applicable, and other members of the Planning Team.

i. Alignment of Care

i. Alignment of care for Members is well-coordinated, integrated care.

ii. The Division and stakeholders have established that reducing or eliminating fragmentation of care for Members requires focused efforts to coordinate physical and behavioral health care with long-term services and supports and community support.

iii. To create greater alignment and care coordination, a single, shared person-centered plan, developed by the Division’s Support Coordinator with the

participation of the DDD Health Plans care management staff, as appropriate, serves as the foundation for care and shall be made available to all involved providers.

j. Integrated Services

i. An integrated care system operated to holistically assess and seamlessly to provide needed services within existing community programs.

ii. An integrated system that reflects that successful Member outcomes are a shared responsibility for all involved in the care and treatment of the Member, leveraging the strengths of the Division, the DDD Health Plans and respective provider disciplines.

B. COMPONENTS OF SUPPORT COORDINATION

1. The Support Coordinator, to provide person centered planning, shall:

a. Provide person-centered planning and coordination;

b. Identifies Cost Effective Services based on assessed need;

c. Develop and maintain the Member's Planning Document;

i. Development of the Planning Document shall be

coordinated with the Responsible Person to ensure mutually agreed upon approaches to meet the Member's needs.

d. Ensures the Responsible Person is informed on how to report the unavailability of services or other problems;

e. Coordinates acute, behavioral health, and long-term care services that will assist the Member in maintaining or progressing toward the Member's highest potential;

f. Reassesses needs and modifies the Member's Planning Document as needed;

g. Identifies appropriate non-ALTCS covered community resources and services for Members and families;

h. Obtains all funded services as assessed in accordance with the Planning Document;

i. Offers a substitute service when the assessed service is not available;

j. Provide facilitation and advocacy

   i. Timely addresses and resolves issues which impede the Member's progress and access to needed services (both ALTCS and non-ALTCS covered

services), and

ii. Ensure services provided are beneficial for the Member.

k. Monitors services for continuing appropriateness

i. Assess for medically necessary and cost effective ALTCS services for the Member.

ii. Evaluate the Member's placement, and authorized services, and taking necessary action to ensure that placement, services, and supports are appropriate to meet the Member's individual goals and needs.

l. Be a mandatory reporter

i. Identifies any instances or suspected instances of abuse or neglect of the Member, reports to the appropriate entities.

ii. Report to the Divisions Quality Assurance Unit all Quality Assurance issues related to non-compliance of contractual requirements related to services the Member is receiving from the Division.

2. The Support Coordinator shall:

a. Follow current Division policy;

b. Comply with all Arizona Health Care Cost Containment System (AHCCCS) requirements;

c. Complete Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) requirements and paperwork;

d. Document accurately;

e. Complete assigned tasks;

f. Be punctual and available.

C. NAVAJO NATION CONTRACTED SUPPORT COORDINATION

1. The Division shall have an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to Members that stipulates:

   a. Who are eligible for Arizona Long Term Services (ALTCS);

   b. Enrolled by the Department of Economic Security with the Navajo Nation to receive support coordination (case management) services;

   c. Affiliated as Members of the Navajo Tribe by virtue of being federally recognized Tribal members and who either live on the Navajo reservation or did live on the Navajo reservation prior to placement in an eligible ALTCS setting;

d. American Indians who are not affiliated members with the Navajo Nation by virtue of being federally recognized members, but currently physically reside on the Navajo reservation or did physically reside on the Navajo reservation but were subsequently placed off reservation in an eligible ALTCS setting.

2. The Navajo Nation contracted Support Coordinator, for Members receiving HCBS on the reservation or in a nursing facility on or off reservation, shall:
   a. Develop and implement a Person-Centered Service Plan;
   b. Coordinate medical needs with the Members' Primary Care Provider (PCP);
   c. Assist the Responsible Person with identifying qualified providers for ALTCS services when they are unable to choose a provider without assistance;
   d. Monitor and update the Person-Centered Service Plan in accordance with this Policy Manual;
   e. Assess the cost effectiveness of services and recommend the least most cost effective service alternatives;
   f. Inform Members of alternative services when the HCBS

services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate;

g. Implement necessary corrective action to bring services into compliance.

3. The Division shall retain various Support Coordination activities:

a. The intake process;

b. Determining and re-determining eligibility;

c. Authorizing services;

d. Monitoring service delivery.

D. SUPPLEMENTAL INFORMATION

Service Coordination responsibilities for the Arizona Early Intervention Program (AzEIP) can be found on the AzEIP Policy and Procedures website.

1620-A INITIAL CONTACT/VISIT STANDARD

REVISION DATE: 12/13/2023, 3/9/2022
REVIEW DATE:
EFFECTIVE DATE: September 7, 2021
REFERENCES: AHCCCS AMPM Chapter 1620-A and E; A.R.S. § 36-551. Division Medical Policy 1620-E

PURPOSE

This policy outlines the timeframe requirements for the initial contact and visit standards for Division Members enrolled in Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

3. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed as cited in A.R.S. § 36-551.

5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.

6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs

through communication and available supports to promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. INITIAL CONTACT WITH A MEMBER WHO IS NEWLY ENROLLED IN ALTCS

1. The Support Coordinator shall review all enrollment notifications received via Focus task, Focus Reports, telephonically, email from AHCCCS, or Pre Admission Screening (PAS) Report when a Member is newly enrolled in ALTCS.
2. The Support Coordinator shall contact the Responsible Person via telephone, in person, or by secure email within five (5) calendar days of enrollment notification to schedule a planning meeting, even if the Member is enrolled during a hospital stay.
3. The Support Coordinator shall conduct an in-person on-site visit to initiate the Person-Centered Service Plan within ten (10) working days of the Member's enrollment notification.

4. The Support Coordinator shall complete the in-person on-site visit as soon as possible if the information obtained during the initial contact or from the Pre Admission Screening (PAS) tool completed by AHCCCS during the ALTCS eligibility determination indicates the Member has more immediate needs for services.
5. The Support Coordination shall conduct the in-person on-site visit at the Member's place of residence, or institutional setting for Members who are enrolled during a hospital stay, in order to develop the Member's Planning Document.
6. The Member shall be present for, and be included in, the in-person on-site visit and at all planning meetings.
7. The Support Coordinator shall allow the Member to decide who should be part of the planning meeting unless participants are specified by rule or law, such as by guardianship.
8. The Support Coordinator shall assess for home and community based services, which shall be initiated within thirty (30) calendar days of the Member's enrollment.
9. The Support Coordinator shall explain the Member's rights and responsibilities including the procedures for filing a grievance or

appeal and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.

10. The Support Coordinator shall participate in proactive discharge planning and follow-up activities for members enrolled with ALTCS during a hospital stay. Refer to Division Medical Policy 1620-E for requirements regarding in-person on-site reviews following a member's discharge from an inpatient hospital stay.
11. The Support Coordinator shall create a Request to Schedule a Meeting to be left at, or sent to, the Member's residence requesting that the Member contact the Support Coordinator if the Support Coordinator is unable to locate or contact the Member via phone, email, mailed letter, or in-person visit.
    a. The Support Coordinator shall complete an Electronic Member Change Report (EMCR) for potential loss of contact if there is no contact from the Responsible Person within thirty (30) calendar days from the Member's date of ALTCS enrollment.
    b. The Support Coordinator shall continue attempts to reach

the Responsible Person until ALTCS disenrolls the member.

12. The Support Coordinator shall document in the Member's case file and Focus progress notes all contact, whether attempted or successful, regarding a Member who is ALTCS eligible.

1620-B NEEDS ASSESSMENT/CARE PLANNING STANDARD

EFFECTIVE DATE: 7/6/2021

REFERENCES: AHCCCS AMPM Chapter 1620-B; A.R.S. § 36-401; A.R.S. § 36-551; 9 A.A.C. 22 Article 1; 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

PURPOSE

This Policy establishes requirements regarding needs assessment and care planning.

DEFINITIONS

Own Home - A residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

1. Health care institution under A.R.S. § 36-401.
2. Residential care institution under A.R.S. § 36-401.
3. Community residential setting under A.R.S. § 36-551, or
4. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

Person-Centered Service Plan (PCSP) A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost-effective outcomes.

Planning Document - A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as defined in A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative.

Planning Team - A group of individuals that shall include the member, Responsible Person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.

Prior Period Coverage (PPC) - For Title XIX members, the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital

Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, Prior Period Coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis.

Responsible Person - Means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551

Support Coordination - A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost-effective outcomes.

Policy

A. Support Coordinators are is expected to use a person-centered approach regarding the member assessment and needs identification, considering not only ALTCS covered services, but also other needed community resources as applicable. Support Coordinators shall:

1. Respect the member and the member's rights.
2. Support the member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible.
3. Provide adequate information and education to support the member/Responsible Person to make informed decisions and choices.
4. Be available to answer questions and address issues raised by the member/Responsible Person, including between regularly scheduled Planning Meetings.
5. Provide a continuum of cost effective service options that supports the expectations and agreements established through the planning process.
6. Educate the member/Responsible Person, on how to report unavailability or other problems with service delivery to ensure unmet service needs can be addressed as quickly as possible. Refer to Division Medical Policy 1620-D and 1620-E, and 540 regarding specific requirements.
7. Facilitate access to non-ALTCS supports and services available throughout the community, ("natural supports") as well as Non-Title XIX services for members with a Serious Mental Illness (SMI) designation.
8. Advocate for the member and/or family/significant others as the need occurs.

9. Allow the member/Responsible Person to identify their role in interacting with the service delivery system, including the extent to which the family/informal supports will provide uncompensated care.

10. Provide member/Responsible Person with flexible and creative service delivery options.

11. Educate member/Responsible Person about member directed options for delivery of designated services. These options will be reviewed with the member/Responsible Person for members living in their own homes at every Planning Meeting.

12. Educate member/Responsible Person on the option to choose a spouse as the member's paid attendant caregiver.

13. Provide necessary information to providers about any changes in member's goals, functioning and/or eligibility to assist the provider in planning, delivering, and monitoring services.

14. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member.

15. Educate the member/Responsible Person on End-of-Life Care and Advanced Care Planning, services and supports. See Division Operations Policy 1006 for additional guidance regarding health care directives.

16. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self- sufficiency in the areas of housing, education, and employment, including volunteer opportunities (refer to the section below which outlines additional requirements for individualized member goals).

17. If a member's status has improved that s/he may no longer be medically eligible for ALTCS, the Support Coordinator shall complete an Electronic Member Change Report (EMCR), for a medical PAS Reassessment.

B. The involvement of the member/Responsible Person in strengths/needs identification as well as decision-making is a basic tenet of Support Coordination practices. For the Planning Meetings, the Planning Team may include anyone, as requested by the member/Responsible Person. The member/Responsible Person and Planning Team partner with the Support Coordinator in the development of the Planning Document, with the Support Coordinator generally functioning as the facilitator.

C. The Support Coordinator will complete the Division's Member Level of Care Tool (MLOC) based on information from the member's Planning Document to determine the member's current level of care.

D. Person-centered plan is based on face-to-face discussion with the member/Responsible Person and other members of the Planning Team in order to

develop a comprehensive Planning Document, as defined in this policy. The Planning Document will include recommendations of the member's Primary Care Provider (PCP), as well as input from service providers, as applicable. Support Coordinators will complete the (DDD-2039A) HCBS Member Needs Assessment Tool to determine the amount of service hours a member needs when Attendant Care/Homemaker, Habilitation Hourly, and/or Respite services will be authorized for members living at home. If the member has been assessed for Respite, the Respite Assessment Tool must also be completed.

E. In development of the member's Planning Document, Support Coordinators shall assist in identifying meaningful and measurable individualized goals for members, including long-term and short-term goals (e.g., in the areas of recreation, transportation, friendships, family and other relationships) to assist the member in attaining the most self-fulfilling, age-appropriate goals consistent with the member's needs, desires, strengths, and preferences.

1. Goals will include steps that the member will take to achieve the goal(s).
2. Goals will be written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.
3. Goals will be reviewed at each Planning Meeting.

F. For members who have been receiving Home and Community Based Services (HCBS) during the Prior Period Coverage (PPC) timeframe a retrospective assessment must occur to determine whether those services were:

1. Medically necessary,
2. Cost effective, and
3. Provided by a registered AHCCCS provider.

If all three of these criteria are met, the services are eligible for reimbursements specified in the member's Planning Document. Services that will be retroactively approved based on this assessment will be marked as "Retroactive" in the Planning Document. If any of the services provided during the PPC are not approved, the member must be provided a written Notice of Adverse Benefit Determination (NOA) and given an opportunity to file an appeal.

G. For new member residing in an Assisted Living Facilities (ALF) during PPC, the support coordinator shall inform the ALF that they are encouraged to bill/accept Medicaid payment for services for members who are eligible under PPC but are not required by regulations to do so. If the facility chooses to, or is required by contract to bill the Division, the facility must accept the Medicaid payment as full payment and is not permitted to bill the member or family for the difference between the Medicaid and private pay rate. The support coordinator shall ensure that the facility refunds private payments made by the member or family, less the amount of room

and board assigned by the Contractor, prior to billing the Division for Medicaid reimbursement.

H. In addition to the grievance and appeals procedures described above, Division of developmental Disabilities (DDD) will also make available the grievance and appeals processes described in Division Operations Policy 446.

1620-C COST EFFECTIVENESS STUDY

EFFECTIVE DATE: 7/6/2021
REFERENCES: A.R.S 36-551

DEFINITIONS

Home and Community Based Services (HCBS) - Home and community-based services, as defined in R6-6-1501.

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Planning Document - A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as defined in A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative.

Planning Team - A group of individuals that shall include the member, responsible person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.

Responsible Person - Means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.

Support Coordination - A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

POLICY

Cost Effectiveness Study

Home and Community Based Services (HCBS) provided under the ALTCS Program must be cost-effective when compared to the cost of providing care to the member in an institutional setting. It is the responsibility of the Planning Team to identify if the member will exceed 100% of the institutional cost and develop a plan to reduce ALTCS expenses. Written Cost Effectiveness Studies (CES) are also required by Arizona Health Care Cost Containment System (AHCCCS), for ALTCS eligible members whose costs exceed 80% of their approved rate.

The CES is a three-month projection of costs. The Support Coordinator shall complete a Cost Effectiveness Study (CES) Worksheet if the member's name appears on the quarterly report "Client_0060 – Individuals Exceeding 80% Cost Effectiveness" (CLT_0060). This report identifies members whose costs exceeded 80% of the institutional rate for one or more months during the prior quarter.

In addition to members on the CLT_0060 Report, there are other circumstances in which the Support Coordinator is required to complete a CES worksheet prior to implementation of services or change in placement. These include when a member's service assessment documents the need for:

A. Nursing services (including nursing respite) in excess of 200 hours monthly

B. Habilitation – Nursing Supported Group Home services

C. Residential Habilitation (Individually Designed Living Arrangement or Group Home) and Day Treatment and Training when the member needs a staff ratio of 1:1 or 1:2 in either setting.

D. Habilitation, Community Protection

E. A change in placement, staffing and/or services that could potentially put the member's costs above 80% cost effectiveness (e.g. move from home to a group home, move from one group home to another group home, adding Day Program with an enhanced staffing ratio, etc.) or discharge from an institutional placement in under consideration.

    1. The costs used for the CES should be those proposed for the new placement.

    2. The Support Coordinator is responsible for completing the CES worksheet and submitting to the Supervisor to check for accuracy and approval.

    3. The Discharge Plan from an institutional placement must be consistent with AHCCCS and Division policy and be developed prior to any move. As needed, the Support Coordinator will ensure coordination with the health plan occurs.

    4. If the costs of the proposed placement are projected to be below 100% of the appropriate institutional level and the move is approved, the Area Manager/designee will ensure the CES is entered in the AHCCCS computer system.

    5. If the costs of the proposed placement are above 100% of the institutional level, discharge cannot be approved.

COMPLETING THE COST EFFECTIVENESS STUDY

The following Home and Community Based Services must be included on the CES Worksheet:

A. Assisted Living Facilities

B. In-Home Support Services (e.g. Attendant Care, Habilitation Hourly, Respite, Homemaker)

C. Day Program (e.g. Day Treatment & Training Adult or Child, Employment Services) and Transportation - Scheduled

D. Emergency Alert Systems

E. Habilitation (Residential, Individually Designed Living Arrangement, etc.)

F. Home Delivered Meals

G. Nursing (continuous or “shift" nursing of 2 hours or more at a time, Nursing Respite)

H. Specific Behavioral Health Services provided through the member’s integrated health plan:

1. Behavioral Health Respite

2. Behavioral Health Alternative Residential Settings

The following services are not included:

A. Occupational, Physical, Respiratory, and Speech Therapy

B. Room and Board

C. Therapeutic Day Program

D. Behavior Management (Behavioral Health Personal Care, Family Support, Peer Support)

E. Psychosocial Rehabilitation (Behavioral Health Living Skills Training)

F. Behavioral Health Services not Listed Above (e.g., medication management)

G. Home Health Aide

H. Nursing provided on an “intermittent” or “per visit” basis (not to exceed 2 consecutive hours per visit and no more than 4 visits per day)

I. Home Modifications

J. Community Transition Services

K. Physical health services provided by the health plan (e.g. Hospice services, customized DME, medical supplies and pharmaceuticals

L. Interpretation or translation services

The services, units, and costs projected on the CES Worksheet are for the upcoming quarter. Each CES Worksheet must be signed by the Support Coordinator. In addition, the Support Coordinator Supervisor is responsible for signing the Worksheet if the member's costs are projected to exceed 80% cost effectiveness. The Supervisor's signature indicates that the Worksheet has been reviewed for accuracy and costs are being monitored. Completed signed CES Worksheets must be maintained in the member's case record.

For CES' that are projected to exceed 100% cost effectiveness for one or more months of the quarter, a Cost Reduction Plan must be identified on the CES Worksheet. In addition to the Support Coordinator and Supervisor's signature, the District Program Manager must also sign the worksheet. This signature assures that all appropriate CES policies and procedures have been followed, including the identification of a Cost Reduction Plan and potential use of State dollars.

A revised CES should be completed and submitted by the Support Coordinator through their chain of command anytime during the quarter when there is a proposed change in placement or service costs that puts the member above 100% cost effectiveness (e.g. vacancy created in group home, staffing increase, enhanced ratio in the day program). Likewise, if there is a change in circumstances during the quarter that reduces costs below 100%, a revised CES should be completed.

The Support Coordinator is required to complete and submit a CES Worksheet quarterly until costs are demonstrated to fall below 80%. The Area Manager/designee will ensure the CES is entered into the AHCCCS computer system prior to the beginning of the quarter that is being projected or within 10 working days of any placement/service change, whichever is sooner.

The Area Manager/designee is responsible for tracking that CES' are completed at least quarterly. In addition, when a member who is over 80% cost effectiveness, transfers from one unit or district to another unit or district, the case transfer procedure will be followed.

SHARE OF COST

Prior to completing the CES worksheet, the Support Coordinator should verify s/he is using the member's most current CES Share of Cost (CES SOC). The CES SOC is the amount the member would have to pay monthly if placed in an institutional setting. The CES SOC amount is determined by AHCCCS and is based on the member's income and expenses. Members who only receive Supplemental Security Income (SSI) typically have $0 CES SOC. However, members who have other types of income (e.g. Social Security Survivors Benefits, VA, Adoption Subsidy, etc.) will have a CES SOC.

The CES SOC is subtracted from the member's approved institutional rate to determine the Net Institutional Cost. The Net Institutional Cost is used to determine whether the services provided to the member are cost effective when compared to an appropriate institutional placement.

WHEN THE CES IS OVER 100% COST EFFECTIVENESS

Once the member's costs have exceeded 100% of the Net Institutional Rate, the Support Coordinator should immediately consult with their supervisor, area manager, and other District personnel (nurse, Network staff, etc.) to develop a plan to reduce costs within six months and determine which options should be pursued.

AHCCCS allows up to six months from the time the member exceeds 100% cost effectiveness to implement a Cost Reduction Plan. If it is unlikely that costs can or will be reduced within six months, the Support Coordinator is responsible for initiating a review of other options.

District management is responsible for tracking and monitoring from the time the member exceeds 100% cost effectiveness until costs are reduced below the member's approved institutional rate.

Options the District may want to consider when a member exceeds 100% cost effectiveness include, but are not limited to:

1. Reconvene the Planning Team to review services and the member's level of support
2. Request a higher medical rate
3. Request a higher behavioral health rate
4. Consideration of possible institutional placement

A. Reconvene the Planning Team to Review Services and the Member's Level of Support

The Support Coordinator, in conjunction with their Supervisor/Area Manager, may need to call a special team meeting to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced. Options the Planning Team could discuss include, but are not limited to:

1. Reduce service units
2. Reduce staffing levels
3. Alternative placements
4. Filling vacancies

B. Request a Higher Medical Rate

If the member has skilled nursing needs, a higher medical institutional rate may be considered by the team. The Support Coordinator must complete a packet that includes the following:

1. Narrative describing how the person meets the criteria

2. Current nursing assessment that identifies the need for skilled nursing care

3. Current CES Worksheet

4. Plan to Reduce Costs - The plan should identify the specific steps the team is taking to address the member's health and safety as well as how the team is monitoring and addressing costs.

Members who are ventilator dependent or authorized for a nursing supported medical group home have been determined to have skilled care needs. Thus, these members are pre-approved for a higher medical institutional rate and a packet does not need to be submitted. However, if the member's circumstances change (i.e. is weaned off the ventilator or no longer resides in a nursing supported medical group home), a Higher Medical Rate packet may be needed if the member continues to have skilled care needs and is over 100% cost effectiveness.

C. Request the Higher Behavioral Health Rate

If the member has a mental health diagnosis and significant behavioral health challenges, the Higher Behavioral Health Rate might be appropriate. These behavioral challenges by the member might include:

1. Behaviors that currently impact the member's functioning or ability to adapt to community life.

2. A substance abuse disorder and significant difficulties adapting to community life.

3. Charged with a crime of sexual violence, including but not limited to, rape, statutory rape, and child molestation.

4. Charged with acts directed toward strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization

5. Has committed one or more violent crimes, such as murder, attempted murder, arson, first-degree assault, kidnapping, or use of a weapon to commit a crime.

The Support Coordinator must complete a packet that includes the following:

1. Narrative describing how the person meets the criteria. This narrative must contain the following:

   - Current psychiatric diagnoses

   - Current behaviors and frequency of these behaviors within the last six months. Include how the team is addressing these behaviors (e.g. Behavior Treatment Plan, Behavioral Health Treatment Plan, behavioral health services the member is currently receiving to address these behaviors).

- Description of how the member currently has difficulty adapting to community life
- Description of substance abuse issues (if applicable)
- Description of criminal offenses (if applicable)

2. Current CES Worksheet
3. Plan to Reduce Costs - The plan should identify the specific steps the team is taking to address the member's behaviors and reduce service costs.
4. The Division's Behavioral Health Administration may request additional documentation, such as current psychiatric and psychological evaluations or the member's approved Behavior Treatment Plan (BTP), to assist in evaluating the request.

RESPONSE FROM THE DIVISION'S HEALTH CARE OR BEHAVIORAL HEALTH SERVICES

DDD's Health Care or Behavioral Health Administration will notify the Operational Compliance Unit of the status of the request for the higher institutional rates (medical and/or behavioral). The Operational Compliance Unit will inform District Support Coordination of the outcome of the request.

- If approved, the notification will include the approval expiration date. If the member continues to need a higher institutional rate, a renewal request should be submitted 30 days prior to the expiration date.
- If denied, the Support Coordinator, in conjunction with the Supervisor/Manager will reconvene the team to consider other options.
- If the approval expires, the institutional rate will revert to the "Base ICF/ID" rate. The Support Coordinator, in conjunction with their Supervisor/Manager must initiate review of the other remaining options listed above if the member remains above 100% cost effectiveness.

D. Considerations for Possible Institutional Placement

When considering institutional placement, the Support Coordinator must first document all other options considered and the reasons why these options were not chosen by the team. The Planning Team must discuss the lack of appropriate, cost - effective alternatives for the member and discuss potential placements. The member/designated representative's decision regarding institutional placement shall be documented in the member's case record. Documentation shall be submitted to the District Program Manager for potential use of state dollars above 100% cost effectiveness.

Procedures for Reducing Cost Below 100%

The District Program Manager or designee is responsible for tracking and monitoring members who are identified as exceeding 100% cost effectiveness. This includes

identification and monthly reporting of members on the Expenditure Correction (EXCOR) Report.

- If costs have not been reduced within six months from the time the member began exceeding 100%, the District Program Manager must determine whether State funds will be approved.
- If there is no Cost Reduction Plan, Support Coordination will obtain approval from the District Program Manager for the use of state funds.
- If the District Program Manager approves home and community-based services above 100% of the cost of serving the member in an institutional setting, these costs must be paid with State funds.
- If State funds will be used, the Area Program Manager/designee will adjust the CES Worksheet calculation previously entered into the AHCCCS computer system to reflect Medicaid approved costs up to, but not exceeding 100% of the member's approved institutional rate. A copy of the AHCCCS computer screen prints showing adjusted CES costs below 100% will be sent to the Support Coordinator and filed in the member's case record.
- If the District Program Manager denies the use of State funds, Support Coordination shall initiate termination of service costs more than 100%. The Support Coordinator shall advise the member/designated representative of the cost effectiveness limitations and discuss other options. Support Coordination shall also follow the Notice of Adverse Benefits Action requirements.

If the member/designated representative chooses to have the member remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member's Primary Care Provider), a Managed Risk Agreement must be completed.

1620-D PLACEMENT AND SERVICE PLANNING FOR ALTCS ELIGIBLE MEMBERS

REVISION DATES: 8/2/2023, 2/16/2022, 9/8/2021

EFFECTIVE DATE: July 6, 2021

REFERENCES: Title 42 U.S. Code 1320a-7b, A.R.S. §36-551, AMPM Chapter 1600, Division Medical Policy 1620-B, Division Medical Policy 1620-C, Division Medical Policy Chapter 300, Division Medical Policy Chapter 1200, Division Operations Policy 4002

PURPOSE

This policy applies to Division Members who are eligible for Arizona Long Term Care Services (ALTCS) and all Division staff. It outlines the requirements for Member placement and service planning for Members eligible for ALTCS.

DEFINITIONS

1. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed. Services subject to EVV include non-skilled in-home services and home health services pursuant to 42 U.S.C. §1396(b)(l).

2. "Gap in Services Subject to EVV" means the difference between the number of hours of these services documented in each Member's Planning Document and the hours of the type of these services that are actually delivered to the Member. The following situations are not considered gaps:

   a. The Member is not available to receive the service when the caregiver arrives at the Member's home as scheduled.

   b. The Member refuses the caregiver when she/he arrives, unless the caregiver is not able to do the assigned duties.

   c. The Member refuses services.

   d. The Member's home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

3. "Home and Community Based Services (HCBS)" means home and community-based services, as defined in R6-6-1501.

4. "Managed Risk Agreement" means a document developed by the Support Coordinator or District Nurse with the Responsible Person, which outlines potential risks to the Member's safety and well-being because of choices or decisions made by the

Responsible Person.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

6. "Out-of-State Services" means services provided to Members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.

7. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

   a. Health care institution under A.R.S. § 36-401.

   b. Residential care institution under A.R.S. § 36-401.

c. Community residential setting under A.R.S. § 36-551, or

d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

8. “Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

9. “Planning Team” means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.

10. “Responsible Person” means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551

11. "Share of Cost" means the amount an ALTCS Member is required to pay toward the cost of long term care services.

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

13. "Temporarily Out of State" means A Member is considered temporarily absent from Arizona if

    a. Intends to return to Arizona when the reason for the absence is completed

    b. Has not become a resident of another state. For minors under the age of 18, residency is based on the custodial parent. A resident of another state includes, but not limited to applying for medical assistance in another state; renting or buying a home; getting a job; and/or applying for a driver's license or identification in another state.

POLICY

A. PLACEMENT AND SERVICE PLANNING STANDARDS

1. The Division shall identify placement goals through a

Member-centric planning process and cost effectiveness standards shall be met in the Home and Community Based setting.

2. The Support Coordinator shall facilitate placement and services based primarily on the Member's choice with additional input in the decision making process from the Planning Team, the Support Coordinator's assessment, and the Pre-Assessment Screening.

3. Support Coordinators shall not use referral agencies to identify placement options for Members in lieu of the Division's contracted network of providers.

4. The Support Coordinator shall discuss the cost effectiveness, as applicable, and availability of needed services with the Responsible Person as part of the Planning Meeting.

5. In determining the most appropriate service placement for the Member, the Support Coordinator and the Responsible Person shall discuss the following as applicable:

   a. The Member's placement choice and preferences,

b. Services necessary to meet the Member's needs in the most integrated/least restrictive setting. Refer to Division Medical Manual Chapters 300 and 1200 for information about the following types of services available:

   i. Home and Community Based Services (HCBS),

   ii. Institutional services,

   iii. Physical health (acute care) services, and

   iv. Behavioral health services.

c. The Member's interest in and ability to direct their own supports and services.

d. The availability of HCBS in the Member's community.

e. Cost effectiveness of the Member's placement and service choice.

f. Covered services that are associated with care in a licensed institutional setting compared to services provided in the Member's Own Home or an HCBS residential setting.

g. The risks that may be associated with the Responsible Person's choices and decisions regarding services, placements, caregivers, which would require the completion of a Managed Risk Agreement (Form DDD-1530A).

h. The Member's financial responsibility as specified in Division Operation Policy 4002.

i. The Member's Share of Cost (SOC) responsibility. The amount of the Member's SOC shall be determined and communicated to the Responsible Person by AHCCCS.

j. The room and board amount to be covered by the Member to be paid towards the cost of the Community Residential Setting.

   i. For Members residing in other alternative residential settings including Community Residential Settings, this is the amount the Member is responsible for paying toward their room and board. Room and board is not an ALTCS covered service in these

settings.

ii. For vendor operated settings that contract directly with the Division, the amount is determined by the Division and shall be communicated to the Responsible Person.

iii. The behavioral health provider shall communicate the room and board amount directly to the Responsible Person for behavioral health residential settings.

iv. The Support Coordinator shall complete an Assisted Living Agreement (Form DDD-1747A) or a DDD Residency Agreement (Form DDD-2176A) for Members who live in Assisted Living or Community Residential Settings prior to the Member's entry into residential services and update the assessment when changes in the Member's income or the provider's rates occur.

6. The Division shall allow any Member who lives in their Own

Home to remain in their Own Home as long as HCBS are cost effective. The Division shall not require Members to enter a residential HCBS placement/setting that is "more" cost effective.

7. The Division shall inform Members that they have the choice to select their spouse to be their paid caregiver for medically necessary and cost effective services, provided the spouse meets all of the qualifications as specified in Division Medical Policy 1240.

8. The Support Coordinator shall complete the Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) with the Member and spouse prior to the authorization of the Member's spouse as the paid caregiver. The Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) form shall be completed at least annually.

9. The Support Coordinator shall coordinate services with the appropriate providers as identified and agreed to in the Member's Planning Document. The Member's assessed needs and corresponding authorization shall not be contingent upon the provider meeting the requirements of the U.S. Department of

Labor, Fair Labor Standards Act.

10. The Support Coordinator shall ensure that the Responsible Person understands that some services and medical supplies require a prescription by the primary care provider (PCP). These include home health services, therapies, and durable medical equipment (DME).

11. The Support Coordinator shall coordinate with the Member's ALTCS Health Plan to obtain a PCP when the Member does not have a PCP or to change the PCP when an ALTCS Member does not have a PCP or wishes to change PCP.

12. The Division shall make a decision regarding the provision of services requested within:

    a. 14 calendar days following the receipt of the request/order, or

    b. Three business days when the Member's life, health, or ability to attain, maintain or regain maximum function would otherwise be jeopardized

13. The Division shall provide appropriate placement and services to

meet the Member's needs within established timelines:

a. Services determined to be medically necessary and cost effective for a newly ALTCS enrolled Member shall be provided to the Member within 30 calendar days of the Member's enrollment.

b. Services for an existing ALTCS Member shall be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

14. The Support Coordinator shall verify the needed services are available in the Member's community and:

c. Shall substitute a combination of other services, when an assessed service is not currently available, to meet the Member's needs until the assessed service becomes available.

d. May assess a temporary alternative placement if services cannot be provided to safely meet the Member's needs.

15. The Support Coordinator shall ensure Members have access to transportation and support for the purpose of visiting potential

residential or non-residential settings prior to making a decision on where to live or receive services.

16. The Support Coordinator shall develop the Planning Document. The role of the Planning Team in developing the Planning Document is communicating and working towards the Member's vision for the future.

17. The Support Coordinator shall document the following in the Planning Document:

    a. The Member's strengths, goals, preferences, needs, and desired outcomes.

    b. The assessed services and supports identified to assist the Member in achieving their established goals. For each ALTCS covered service, the Planning Document shall document the frequency and quantity of the service including any change to the service since the last Planning Meeting.

    c. Every effort shall be made to ensure the Responsible Person understands the Planning Document, including their

agreement or disagreement with each service authorization. The Support Coordinator shall engage in reasonable conflict resolution efforts to resolve any issues when the Responsible Person disagrees with the service(s) authorized.

d. The Planning Document shall be reviewed according to the timeframes specified in Division Medical Policy 1620-A and Division Medical Policy 1620-E. The Planning Document shall be reviewed sooner when there is a change to the Member's functional needs, circumstances, individual goals, or at the Responsible Person's request.

e. The Support Coordinator shall document how the Member communicated their agreement or disagreement when the Member is physically unable to sign the Planning Document.

f. An adult Member enrolled with the Division shall be assumed legally competent to make decisions on their own behalf unless the Court has appointed a legal guardian. The Support Coordinator shall leave the Planning

Document unsigned and document the circumstances when the Member is unable to participate in the planning and decision making process and does not have a legal guardian. When appropriate, a referral to the County Public Fiduciary or resources shall be considered by the Planning Team.

g. The Support Coordinator shall provide a copy of the Planning Document to the Responsible Person and maintain a copy in the case file. The Support Coordinator shall also provide a copy of the Planning Document to the individuals selected by the Responsible Person, as specified in the Planning Document, and to all authorized service providers (vendors).

h. The Support Coordinator shall assess for risks while considering the Member's right to assume some degree of personal risk. The Planning Document shall also include measures available to reduce risks or identify alternative ways to achieve individual goals based on the Member's priorities outlined in the Planning Document.

18. The Division shall provide the Responsible Person with a Notice of Adverse Benefit Determination that explains the Member's right to file an appeal regarding the placement or service decisions within the Planning Document when the Responsible Person disagrees with the Planning Document and/or authorization of placement/services including the amount and/or frequency of a service.

19. The Support Coordinator shall provide a copy of the DDD-EVV Member Contingency/Back-Up Plan For the Independent Provider Program (Form DDD-2113A). The contingency plan shall be given to the Responsible Person when developed and at the time of each review visit.

20. For services delivered by an independent provider, the Member's contingency/backup plan shall direct the Responsible Person to contact the Support Coordinator or the Division's Customer Service Center when a Gap in Services Subject to EVV occurs during the Division's business hours. The Member's contingency/backup plan shall direct the Responsible Person to the Division's after-hours telephone number for a Gap in

Services Subject to EVV that occurs after regular business hours.

21. The Support Coordinator shall be responsible for completing the Member Contingency/Back-Up Plan with the Responsible Person when any of the following services will be provided by an Independent Provider (IP):

    a. Attendant care

    b. Respite

    c. Habilitation Hourly

    d. Habilitation Independent

    e. Homemaker (Housekeeping)

22. The Support Coordinator shall encourage and assist members who reside in their Own Home to have an emergency/disaster plan for their household that considers the special needs of the Member. Support Coordinators shall document the discussion in the Planning Document with the Responsible person and document the Member's plan on the Emergency/Disaster Plan (Form DDD-1621A) when the Responsible Person requests

assistance with developing an emergency/disaster plan.

23. The Support Coordinator shall regularly assess Members who reside in out-of-home residential placements to determine if they are in the most integrated setting possible for their needs. Members are permitted to change to a less restrictive placement, if needed services are available and cost effective in that setting.

24. The Support Coordinator shall inform the Responsible Person of the process for voluntary withdrawal and guide the Responsible Person through applying for AHCCCS Complete Care, or other programs, as needed, when the Member does not want or need long term care services.

    a. The Support Coordinator shall advise the Responsible Person that the Member may be disenrolled from the ALTCS program based on the Member's income.

    b. The Support Coordinator shall continue their attempts to meet with the Member and their Responsible Person until the Member is disenrolled from ALTCS.

25. The Support Coordinator shall include the date range and units

for each service authorized on the Planning Document and in the Member's case file according to the Division's system for tracking service authorizations.

26. The Division shall include the following types of services in its system for tracking authorized services for Members residing in an institutional setting as appropriate based on the Member's needs:

    a. Nursing facility services. The Planning Document shall indicate the Member's acuity (Level I, II, or III) based on the AMPM Exhibit 1620-3, completed by the District Nurse, and the need for specialty care.

    b. Hospital admissions (acute and psychiatric)

    c. Bed holds or therapeutic leave days, refer to AMPM Policy 100 for definitions and limitations

    d. Services in an uncertified nursing facility

    e. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless of if rented, purchased, or repaired). This requirement shall be waived

for ALTCS/DDD Members.

f. Hospice services

g. Therapies (occupational, physical, and speech)

h. Behavioral health services, refer to the Behavioral Health Service Matrix on the AHCCCS website.

i. ALTCS covered services noted above when provided by other funding sources.

B. TEMPORARILY OUT-OF-STATE HCBS SERVICES

1. The Division shall determine when HCBS Out-of-State Services are appropriate for the Member, medically necessary, and cost effective when requested.

2. The Division shall only cover HCBS Out-of-State Services when they are requested and approved prior to the Member traveling out-of-state.

3. The Division shall not authorize HCBS Out-of-State Services that are requested after the Member has traveled out-of-state.

4. The Support Coordinator shall assess the need for HCBS Out-of-State Services when requested by the Responsible Person. To assess for these services, the Planning Team shall:

   a. Determine if services currently assessed for the Member are appropriate and/or sufficient to meet the Member's needs while out-of-state.

   b. Determine the dates of departure and return.

5. The Division shall notify the Planning Team and the provider/qualified vendor agency of the outcome of the request.

6. The Division shall not authorize Licensed Health Aide (LHA) services for Members traveling Out of State as LHA providers are only licensed to practice in the state of Arizona.

7. The Division shall not cover services for Members who leave the United States and United States Territories.

C. AHCCCS NOTIFICATION REQUIREMENTS

1. The Support Coordinator shall not complete an electronic member change report (eMCR) when reporting a change in the

Member's PCP.

2. The Support Coordinator shall complete an eMCR for an evaluation of Long Term Care/Acute Care Only eligibility when the Member refuses long term care services that have been offered or refuses to allow the Support Coordinator to conduct a review visit in accordance with the required timeframes and locations but do not wish to withdraw from the ALTCS program.

3. The Support Coordinator shall complete and send an eMCR and documentation that further describes the circumstances of a Member's refusal to accept ALTCS services or allow a Support Coordinator to conduct a review visit to the AHCCCS Division of Health Care Management Medical Management Unit.

4. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member anticipates being out-of-state or has been out-of-state for more than 30 days.

5. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member has returned to Arizona when the Member has been out-of-state for more than 30 days.

Signature of Chief Medical Officer: Anthony Dekker (Aug 2, 2023 13:16 PDT)

Anthony Dekker, D.O.

1620-E SERVICE PLAN MONITORING AND REASSESSMENT STANDARDS

REVISION DATE: 07/19/2023
EFFECTIVE DATE: July 6, 2021
REFERENCES: A.R.S. §36-551, AMPM Chapter 1620-E

PURPOSE

This policy establishes the requirements for service plan monitoring and reassessment visits for Members who are eligible with Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Home and Community-Based Services (HCBS)" means home and community-based services, as defined in R6-6-1501.
2. "Member" means the same as "client" as defined in A.R.S. § 36-551.
3. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

a. Health care institution under A.R.S. § 36-401.

b. Residential care institution under A.R.S. § 36-401.

c. Community residential setting under A.R.S. § 36-551, or

d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C.R9.101).

4. "Person-Centered Service Plan (PCSP)" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP will also reflect the Member's strengths and preferences that meet the Member's social, cultural, and linguistic needs, individually identified goals and desired outcomes and reflect risk factors (including risks to Member)

5. "Planning Document" means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), or Person-Centered Service Plan (PCSP).

6. "Planning Team" means a group of individuals that shall include the member, responsible person (as applicable), support coordinator, and a representative from the agency for Members

living in a licensed setting and with the Member's consent, and any individuals important in the Member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551
8. "Serious Mental Illness (SMI)" means a designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older
9. "Serious Mental Illness Determination" means a determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

10. "Special Assistance" means the support provided to a Member designated as Seriously Mentally Ill (SMI) who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.
11. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. SERVICE PLAN MONITORING AND REASSESSMENT VISITS FOR MEMBERS ELIGIBLE FOR LONG TERM CARE SERVICES (ALTCS)

1. The Support Coordinator shall be responsible for the ongoing assessment and monitoring of the needs, services, and residential service setting of each Member they are assigned to assess including, but not limited to:
    a. The continued suitability and cost effectiveness of the services and residential service setting in meeting the Member's needs, and
    b. The quality of the care delivered by the Member's service

providers.

2. The Support Coordinator shall complete the Planning Meeting with the Member present as the Planning Document is about the Member being served.
3. The Support Coordinator shall encourage the Member to actively engage and participate in the development of their Planning Document to the greatest extent possible.
4. The Support Coordinator shall conduct the Planning Meetings where the Member receives services, including the Member's Own Home and other service settings.
    a. The Support Coordinator shall conduct the Planning Meetings with the Member and the Responsible Person, if applicable, in the Member's Own Home at least twice annually to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs.
    b. The Support Coordinator shall conduct the Planning Meeting once a year at one of the Member's service setting locations when a Member receives services in a setting outside of the home.

c. The Support Coordinator shall conduct the remaining Planning Meetings at an alternate location that is not a service setting when the Responsible Person chooses an alternate location for the Planning Meeting.

i. The Support Coordinator shall conduct the Planning Meeting at a service setting or an alternate service setting site, when it is convenient for the Responsible Person and not for the convenience of the Support Coordinator or providers.

ii. The Support Coordinator shall document the Responsible Person's choice of location in the Member's case file.

5. The Support Coordinator shall complete a Planning Document:

a. At the time of the initial Planning Meeting,

b. When there are any changes in services, and

c. At the time of each Planning Meeting, as specified in section B of this Policy.

6. The Support Coordinator shall provide a copy of the signed Planning Document that includes the Responsible Person's indication of whether they agree or disagree with each service

authorization.

B. TIMELINES FOR COMPLETING AND MONITORING THE PLANNING DOCUMENT

1. The Support Coordinator shall complete a Planning Meeting every 90 days for Members in the following scenarios:
   a. Living in their “Own Home”.
   b. Residing in a Child or Adult Developmental Home.
   c. Residing in a group home and the Member is under the age of 12 years old.
   d. Residing in a group home and the Member is medically involved, regardless of age.
   e. Members receiving behavioral health services and/or medication monitoring from a behavioral health provider through their DDD health plan regardless of the Member’s living arrangement.
2. The Support Coordinator shall complete a Planning Meeting every 180 days for Members in the following scenarios:
   a. The Member is 12 years or older, residing in a group home, and not receiving behavioral health services through the Member’s ALTCS health plan, and not medically involved.

b. The Member is residing in a Skilled Nursing Facility (SNF), Intermediate Care Facility/Intellectually Disabled (ICF/ID), or other institutional setting, and not receiving behavioral health services from a behavioral health provider through their DDD health plan.

i. The Support Coordinators shall attend the facility's care planning meetings on a periodic basis to discuss the Member's needs and services jointly with the Responsible Person and the assigned District Nurse when the Member is in an SNF.

ii. The Support Coordinator shall consult with facility staff, the Responsible Person, the assigned District Nurse, and when appropriate, the Division's health plan representative during Planning Meetings to assess changes with the Member and whether discharge from the SNF should be considered.

iii. The Support Coordinator shall request a copy of the facility's Care Planning Meetings to be included as part of the Member's Planning Document and as part of the Member's file.

c. The Member is receiving hospice services in an institutional setting, even if it is a non-Medicare-certified institutional setting.

3. The Support Coordinator shall complete the 90-day Planning Meeting on-site or by telephone, as requested by the Responsible Person when the Member is in Long Term Care and Acute Care Only (LTC/ACO) status and is living in their Own Home and currently does not want or does not need Long-Term Services and Support in LTC/ACO status.

a. The Support Coordinator shall document in the Member's file the Responsible Person's request to conduct the meeting, other than in the Member's Own Home.

b. The Support Coordinator shall complete an on-site home visit with the Member at least once every 12 months.

C. ADDITIONAL MONITORING

1. The Support Coordinator shall respond to the Responsible Person's questions and requests, within 48 hours, not including holidays and weekends, when the Responsible Person contacts the Support Coordinator between regularly scheduled Planning Meetings to ask questions, discuss changes or needs, and to

request a meeting with the Support Coordinator.

2. The Support Coordinator shall take appropriate action when they identify or are notified of an urgent or a potential emergency situation.
    a. The Support Coordinator shall conduct an emergency visit when the situation is urgent and cannot be handled over the telephone.
    b. The Support Coordinator shall be required by law to report to a police officer or protective service worker, when the Support Coordinator identifies any instance of abuse or neglect during the course of a Planning Meeting or during any other contact with the Member.
    c. The Support Coordinator shall report urgent or potential emergencies to Support Coordination management to determine the level of intervention and appropriate action, including referral to quality management.
3. The Support Coordinator may provide more frequent case monitoring following the occurrence of an urgent or emergent need or change of condition, which may require revisions to the existing Planning Document.

4. The Support Coordinator, in conjunction with the Division's Health Care Services and Member's DDD health plan, shall assess and authorize adequate services prior to the Member's discharge to the Member's Own Home, community residential setting, or assisted living setting.

   a. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days following a Member's discharge from an inpatient setting or a change of placement type or from the date the Support Coordinator is made aware of such a change.

   b. The Support Coordinator shall conduct the Planning Meeting to ensure that appropriate services are in place and that the Responsible Person agrees with the Planning Document as authorized.

   c. The Support Coordinator shall conduct a post-discharge Planning Meeting within 10 business days when a Member is discharged from the hospital to a new SNF. A post-discharge Planning Meeting shall not be required for Members discharged from an inpatient hospital stay and returning to the SNF from which they were admitted.

d. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days post-discharge for Members who are enrolled with ALTCS during an inpatient stay in a hospital.

e. The Support Coordinator shall ensure the provision of services identified through the discharge planning, assess for any unmet needs, and ensure that the Responsible Person agrees with the Planning Document.

5. The Support Coordinator shall work in coordination with the District's Complex Care Specialist and the Member's behavioral health provider to assist with coordination of the Member's discharge needs when a Member has been admitted to a behavioral health inpatient facility.

a. The Support Coordinator shall participate in all scheduled Inpatient Treatment and Discharge Plan (ITDP) Meetings within three days of the Member's admission.

b. The Support Coordinator, with the facility's treatment team and representatives of the Planning Team, shall develop a preliminary ITDP within one day and a full ITDP within seven days of a Member's admission when a Member's

anticipated stay is less than seven days. Refer to A.A.C R9-21-312.

c. The Support Coordinator shall review and participate in the review of the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent year that the Member remains in the inpatient facility. Refer to A.A.C R9-21-312.

6. The Support Coordinator shall conduct an on-site Planning Meeting within 30 calendar days when a Member:

a. Moves from a placement type to the same placement type.

b. Starts a new day treatment program or an employment program.

D. ADDITIONAL PLANNING MEETING REQUIREMENTS

1. The Support Coordinator shall meet with the Responsible Person, according to the established standards:

a. The Support Coordinator shall discuss the type, amount, and providers of authorized services.

b. The Support Coordinator shall take and document action taken, when issues are reported or discovered, to resolve

these issues as quickly as possible. The Division shall also be advised of Member grievances and provider issues for purposes of tracking and trending.

c. The Support Coordinator shall assess the Member's current functional, medical, behavioral, and social strengths and needs, including any changes to the Member's informal support system, in accordance with the Needs Assessment and Care Planning Standards as specified in Division Medical Policy 1620-B.

d. The Support Coordinator shall use the Division's, HCBS Member Needs Assessment Tool to review the service hours a Member needs when Attendant Care, Homemaker, and/or Habilitation services shall be authorized for the Member.

e. The Support Coordinator shall utilize the HCBS Member Needs Assessment (Form DDD-2039A) to assess and document the care that is provided and agreed upon by the Member's informal support system.

f. The Support Coordinator shall review the HCBS Member Needs Assessment (Form DDD-2039A) at each Planning

Meeting and include a discussion with the Responsible Person regarding the voluntary provision of informal support.

g. The Support Coordinator shall regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care to the Member.

h. The Support Coordinator shall use the Division's Member Level of Care (MLOC) Tool (Form DDD-2096A) to determine the level of care for all Members not residing in an institutional setting.

i. The Support Coordinator shall complete the Member Level of Care (MLOC) Tool (Form DDD-2096A) every 12 months and review the MLOC Tool at least every 180 days or more often as indicated by a change in Member's condition.

j. The District Nurse, in coordination with the Support Coordinator, shall review and complete the AHCCCS Uniform Assessment Tool (UAT) at least once every 180 days for Members residing in an SNF.

i. This review shall include a comparison with facility

documentation. In addition, for Nursing Facilities, this review shall include documentation from the Minimum Data Set (MDS) to determine changes in the Member's acuity level.

ii. The UAT may be updated more frequently than 180 days as requested by the provider for authorization purposes or when there has been a change in the Member's condition.

k. The Support Coordinator shall assess the continued appropriateness of the Member's current placement and services, including whether the Member is residing in the setting of their choice and whether there are any goals that need to be developed and/or risks to manage related to the Member's service or placement decisions and identify risks that may compromise the Member's general health condition and quality of life. The Support Coordinator shall:

i. Assess the cost effectiveness of services provided or requested,

ii. Discuss with the Responsible Person the progress

toward established goals

iii. Identify any barriers to the achievement of the Member's goals,

iv. Develop and prioritize new and/or existing goals as needed

v. Review service delivery options available to the Member, at each Planning Meeting for Members living in or preparing to transition to their Own Home from an institutional setting or to a community residential setting or Assisted Living setting.

vi. Review and document, at least annually, the Member's continued choice of the Member's spouse as the paid caregiver. Documentation shall include the Member's signature on the Spousal Attendant Care Acknowledgment of Understanding (Form DDD-1469A).

vii. Review, at least annually, the Division ALTCS Member Handbook to ensure the Responsible Person is familiar with the contents, especially as related to covered services and their rights and responsibilities.

2. The Support Coordinator shall coordinate with the Member's behavioral health provider for a referral to a qualified clinician, as specified in A.A.C. R9-21- 101(B) for assessment and evaluation when the Planning Team has identified the need for a Serious Mental Illness Determination. See the Division's Medical Policy 320-P for further details.
3. The Support Coordinator shall coordinate with the assigned advocate from the Office of Human Rights (OHR) assigned to provide the notification for Special Assistance Members with a Serious Mental Illness Determination in accordance with AMPM Policy 320-R.
4. The Support Coordinator shall coordinate with the behavioral health provider to review and discuss the following items for Members who have a Serious Mental Illness Determination:
    a. The outcome of the assessment, the need for further evaluations, as necessary, and any interim services provided.
    b. The existing Inpatient Treatment and Discharge Plan (ITDP), according to A.A.C. R9-21-312, when applicable.
5. The Support Coordinator shall be responsible for following up

with the behavioral health provider for Members receiving behavioral health services to ensure newly assessed services are initiated within 14 calendar days.

6. The Support Coordinator shall refer the case to the Public Fiduciary or other available resources, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members when the Member is not capable of making their own decisions, but does not have a guardian and is not capable of making their own decisions, The Support Coordinator shall document in the case file the reason a Responsible Person is not available.
7. The Support Coordinator shall regularly assess using the Planning Document, Members who reside in a community residential or Assisted Living setting to determine if it is possible to safely meet the Member's needs in a more integrated setting.
8. The Support Coordinator shall review, at each Planning Meeting, with the Responsible Person, the process for immediately reporting any unplanned gaps in service delivery for Members receiving services in their Own Home.
9. The Support Coordinator shall reconvene the Planning Team to

address the gap and, if needed, identify additional strategies to prevent future occurrences when a gap occurs in one or more of the following services.

a. Attendant Care

b. Respite

c. Nursing

d. Homemaker

e. Habilitation Hourly, and

f. Habilitation – Individually Designed Living Arrangement

10. The Support Coordinator shall contact the appropriate provider to address problems or issues identified by the Responsible Person.

11. The Support Coordinator shall contact the Member's HCBS provider, at least annually, if they are not present at the time of the Planning Meeting, to discuss the ongoing assessment of the Member's needs and status.

    a. The Support Coordinators shall review Provider Progress Reports and follow-up if issues or concerns are identified.

    b. The District Nurse shall contact the Home Health Agency quarterly when the Member is receiving skilled nursing

care and document any input received from the Home Health Agency on the Quarterly Nursing Assessment.

c. The Support Coordinator may need to contact the service provider quarterly, for Members receiving behavioral health services, to complete the behavioral health consultation. Refer to Division Medical Policy 1620-G for further details.

12. The Support Coordinator shall refer the case to the Division's Medical Director for review when the Support Coordinator and PCP or attending physician disagree regarding the need for a change in acuity, placement, or physician's orders for medical services. The Medical Director shall be responsible for reviewing the case, discussing it with the PCP or attending physician if necessary, and making a determination to resolve the issue.
13. The Support Coordinator shall discuss with the Responsible Person any potential changes that may necessitate a change of placement or services, determined through the planning process, prior to the initiation of any changes.
14. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person in the event of a denial, reduction, termination, or suspension of services, when the

Responsible Person has indicated, on the Planning Document, that they disagree with the type, amount, or frequency of services to be authorized. Refer to 42 CFR 438.404 and Division Operations Policy 414 for more detailed information and specific timeframes regarding the Notice of Adverse Benefit Determinations.

15. The Division shall provide Members who have a Serious Mental Illness Determination the option to choose between the appeal process for Members who have received a Serious Mental Illness Determination or the standard appeal process. Refer to Division Operations Policy 446.

16. The Support Coordinator shall be aware of the following regarding Members eligible to receive hospice services:

    a. The Responsible Person may elect for the Member to receive hospice services which may be covered by private insurance or Medicare, or by ALTCS if no other payer source is available.

    b. The Medicare hospice benefit shall be divided into two 90-day election periods. Thereafter, the Member may continue to receive hospice benefits in 60-day increments.

A physician shall recertify hospice eligibility at the beginning of each election period, and

c. The Responsible Person shall have the right to revoke the election of Medicare hospice care at any time during the election period and resume ALTCS coverage; however, any remaining days of coverage are then forfeited for that election period.

d. A Responsible Person may also, at any time, again elect to receive Medicare hospice coverage for any other hospice election periods for which they are eligible.

e. The hospice agency shall be responsible for providing covered services to meet the needs of the Member related to the Member's hospice-qualifying condition. Medicaid services provided to Members receiving Medicare hospice services that are duplicative of Medicare hospice benefits shall not be covered.

f. The Support Coordinator may assess and authorize attendant Care services in conjunction with hospice services.

i. The Division shall provide the attendant care service

when the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis. Refer to the Division's Medical Policy 310-J, for additional information regarding hospice services.

17. The Support Coordinator shall only complete a Member Change Report (eMCR) for Members who are ALTCS. The Support Coordinator shall be responsible for using the eMCR process to notify AHCCCS of a variety of changes in the Member's status. Refer to AMPM 1620-2 for a hard copy of the eMCR form and refer to the ALTCS Member Change Report User Guide on the AHCCCS website, for instructions on completing the eMCR.
18. The Support Coordinator shall update the information in Focus as the Division electronically transmits some data fields to AHCCCS.

E. RESPONSIBLE PERSON'S REFUSAL TO COOPERATE

1. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person, indicating the reason(s) for the denial or discontinuance of services when a Support Coordinator is unable to conduct a Planning Meeting, as specified above, due to the Responsible Person's refusal to

cooperate with the provisions, services cannot be evaluated for medical necessity and therefore shall not be authorized.

2. The Support Coordinator shall send a letter to the Responsible Person requesting contact by a specific date within 10 business days to schedule a Planning Meeting.
3. The Support Coordinator shall contact the local ALTCS office to see if they have the Member's current contact information when there is no response by the designated date on the letter.
4. The Support Coordinator shall send an eMCR after 30 days of no contact with a Responsible Person indicating loss of contact to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program.
    a. The Division shall not disenroll a member when the local ALTCS office is able to contact the Responsible Person and confirm the Responsible Person does not wish to withdraw from the ALTCS program.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:11 PDT)

Anthony Dekker, D.O.

1620-G BEHAVIORAL HEALTH STANDARDS

REVISION DATE: 12/22/21
EFFECTIVE DATE: March 3, 2021
SUPERSEDES: 5/13/16
REFERENCES: A.R.S. § 32-3251; A.A.C. R4-6-101, R9-10-101(25)

PURPOSE: This policy establishes Support Coordination requirements for DDD ALTCS eligible members needing or receiving behavioral health services.

The Division covers behavioral health services for members eligible for ALTCS and the Division regardless of the health plan they choose. The responsibilities of the Division for providing behavioral health services to members are outlined in this policy, including additional requirements for members that have chosen Tribal Health Program (THP) as their health plan. The Division is responsible for collaborating with tribal entities and behavioral health providers to ensure access to services for THP members.

DEFINITIONS

Behavioral Health Professional (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091,
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:
    a. A psychiatric-mental health nursing certification, or
    b. One year of experience providing behavioral health services.

POLICY

The following standards apply to members who are ALTCS eligible and need or receive behavioral health services.

A. Direct referrals for behavioral health services may be made by the member/responsible person, Support Coordinator, or a health care professional.

1. When the Support Coordinator receives a request for behavioral health services from the member/responsible person, the Support Coordinator shall send a referral to a behavioral health provider for an initial assessment.

2. When the Support Coordinator identifies the need for behavioral health services, the Support Coordinator shall document the member/responsible person's agreement to services prior to submitting a referral.

3. Referrals shall be made by the Support Coordinator within one business day from the day that the request for behavioral health services was received or the need identified.

B. As appropriate, the Support Coordinator will send a referral for serious mental illness determination to the behavioral health entity. See Division Medical Policy 320-P for further details regarding the behavioral health entity's responsibilities for serious mental illness determination.

C. The Support Coordinator shall ensure members receive behavioral health services in accordance with Behavioral Health Appointment Standards as delineated in Division Operations Policy 417.

1. Urgent need appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need.

2. Routine care appointments:

a. Initial assessment within seven calendar days of referral or request for service, and

b. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but:

i) For members age 18 years or older, no later than 23 calendar days after the initial assessment, and

ii) For members under the age of 18 years old, no later than 21 calendar days after the initial assessment.

c. All subsequent behavioral health services as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

3. For psychotropic medication appointments, the behavioral health entity shall assess the urgency of the need. If clinically indicated, the practitioner shall provide an appointment that ensures that the member:

a) Does not run out of needed medications, or

b) Does not decline in his/her behavioral health condition prior to starting medication but no later than 30 days from the identification of need

4. The Support Coordinator shall follow-up with the behavioral health entity to ensure the member receives timely behavioral health appointments and services.

D. The Support Coordinator shall ensure there is communication with the member's primary care provider and behavioral health providers involved in the member's care and that care is coordinated with other agencies and/or other providers involved in the member's care.

E. For members exhibiting challenging behaviors (new or existing), additional or new interventions may be warranted to support the member in the current setting. The Support Coordinator shall ensure the timely involvement of a Behavioral Health Professional to assess, develop a care plan and preserve the current placement (if possible). For members residing in a non-behavioral health setting refer to AdSS Medical Policy 310-R for information on acute behavioral health situations.

F. Support Coordination for a member receiving behavioral health services shall be provided in collaboration with a qualified behavioral health professional in those cases where the Support Coordinator does not meet the qualifications of a Behavioral Health Professional as defined in A.A.C. R9-10-101. The consultation does not have to be with the provider of behavioral health services. It may be with a qualified designee within the Division.

G. The Support Coordinator shall make contact with the behavioral health professional prior to the initial behavioral health consultation for all members receiving/needing behavioral health services. At minimum, quarterly discussions (or more frequent, as warranted) between the Support Coordinator and the behavioral health professional are required as long as the member continues to receive/need behavioral health services.

H. Initial and quarterly discussions are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.

1. The Support Coordinator shall document the content and results of the initial and quarterly discussions with the behavioral health professional. The

discussion must be a communication between the Support Coordinator and a behavioral health professional regarding the member's status and plan of treatment. A report received and placed in the member's case file by the Support Coordinator from the behavioral health professional does not meet the requirement for initial and quarterly discussions between the Support Coordinator and the behavioral health professional.

I. As part of the care planning and service plan monitoring, the Support Coordinator shall review the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this special monitoring. Examples of medication uses that do not require this monitoring are sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms and anticonvulsants used to treat a seizure disorder.

J. Documentation of the medication review shall be evident in the member case file. The review shall take place at each Planning Meeting and include the purpose of the medication, the effectiveness of the medication, and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, multiple medications apparently prescribed for the same diagnosis) shall be discussed with the behavioral health consultant and/or prescribing practitioner. The Planning Document and electronic progress notes shall reflect this discussion and include a plan of action to address these issues.

K. Support Coordinators are responsible for identifying, assisting with, and monitoring the special needs and requirements related to members who are unable or unwilling to consent to treatment (i.e., petitioning, court-ordered treatment and judicial review). The Support Coordinator shall document in the member's electronic progress notes a coordination with the behavioral health entity related to these activities.

L. The behavioral health code is updated in Focus at the time of each behavioral health professional consultation.

1620-K SKILLED NURSING NEED STANDARD

EFFECTIVE DATE:
REFERENCES: AMPM 1620-K, Medical Policy Manual 1240-G, Medical Policy Manual Exhibit 1240G-1

PURPOSE

This policy establishes support coordination standards for members with skilled nursing needs.

DEFINITIONS

Division Contracted Nursing Agency is a Medicare Certified Home Health Agency (HHA) that is licensed by the Arizona Department of Health Services (ADHS), registered with AHCCCS, and contracted with the Division of Developmental Disabilities.

Institutional Settings are a long-term care arrangement in which skilled nursing services can be provided. Institutional Settings include:

- Nursing facility, including religious non-Medical Health Care Institution
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Behavioral Health Inpatient Facility
- Institutions for Mental Disease (IMD) and
- Inpatient Behavioral Health Residential Treatment Facility

Non-Institutional (Home and Community Based/HCBS) Settings are a long-term care arrangement in which skilled home health nursing services can be provided. Non-Institutional Settings/HCBS settings include:

- A members "own home", as defined in A.A.C. R9-28-101(B)
- Assisted Living Facility
- DDD Group Home
- DDD Adult & Child Developmental Home
- Behavioral Health Residential Facility

POLICY

In conjunction with the Health Care Services (HCS), the Support Coordinator is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet the member's individual needs. District Nurses do not provide "hands on" direct nursing but are available to assist Support Coordinators with assessing and coordinating care related to the member's overall physical health.

A. Non-Institutional/HCBS Settings

1. A member who has skilled nursing needs (e.g., pressure ulcers, surgical wounds, tube feedings, and/or tracheotomy) shall be referred to the Division's Health Care Services (HCS) for the initial assessment. Refer to the Division's Medical Policy Manual, Exhibit 1240G-1 for a list of medical conditions and

needs that require skilled nursing tasks.

2. To assist with coordination of care and improve the member's overall health, there are other circumstances in which a referral for a nursing assessment shall be initiated by the Support Coordinator. These situations include, but not limited to:
   a. The member is at risk of compromised skin integrity (e.g., impaired circulation, obesity, extreme weight loss, difficulty shifting their weight in a bed or chair, autoimmune disorders, etc.)
   b. The member has a history of medical instability (e.g., frequent and/or uncontrolled seizures, unstable diabetes)
   c. The member has a change in behaviors not explained by a change in behavior treatment plan or behavioral medications, and consultation with a Qualified Behavioral Health Professional already occurred.
   d. Has multiple medical and/or behavioral challenges
   e. The member is over the age of 21 and has extensive dental concerns including decay, infection, or pain
   f. There has been a change in medical condition, a new skilled nursing need, or a change to an existing skilled nursing need
   g. There have been three or more trips to the Emergency Room in a six-month period
   h. Has multiple admissions to the hospital within 30 days
   i. Has been enrolled or will be enrolled in hospice care
   j. An enhanced ratio in Day Treatment and Training Program due to a medical condition is being considered by the member's Planning Team.

3. The Support Coordinator shall submit a referral to HCS for a skilled nursing assessment within two days of the date the potential need for nursing was identified. The Support Coordinator can also contact the District Nurse if they are unsure if a referral for a nursing assessment is needed.

4. The District Nurse will coordinate a meeting with the member/responsible person and Support Coordinator and complete the nursing assessment for skilled nursing services within 14 days of the referral. When possible, the Support Coordinator shall attend the nursing assessment and any follow up re-assessments. These joint meetings will assist with the coordination of care and services to meet the member's needs.

5. The member shall be monitored for skilled nursing needs by the District Nurse at least every 90 days and more frequently as needed. The District Nurse can make recommendations to the Primary Care Provider (PCP) and to the planning team for continued monitoring.

6. Upon receiving the authorization for nursing services, the Division contracted nursing agency shall obtain an order from the Primary Care Provider (PCP) to perform duties related to home nursing care. The plan of care shall be reviewed by the member's Planning Team and incorporated into the member's Planning Document. For further information regarding the details included in a nursing plan of care, see Medical Policy Manual 1240-G

7. If the member/responsible person refuses a nursing assessment or the skilled nursing service, the District Nurse and Support Coordinator shall inform the member/responsible person of the possible risks of refusing such care. The District Nurse shall utilize a Managed Risk Agreement (MRA) to document the reason given for refusing the recommended care and that the member/responsible person has been informed of the risks. The member/responsible person shall sign this agreement.

    a. If the member is requesting an alternative service be provided in lieu of skilled nursing (e.g., Attendant Care or Habilitation), the MRA shall document the member/responsible person's understanding that when the Attendant Care or other alternative service is utilized, skilled tasks shall not be provided and will not be paid for by the Division."

    b. The member's PCP shall also be informed by the District Nurse or Support Coordinator of the member/responsible person's refusal for skilled nursing care.

Refer to Division's Medical Policy 1240-G, for additional guidelines regarding medically necessary home health services for members.

B. Institutional Settings

1. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromised skin integrity (e.g., being bedridden, quadriplegia, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.

2. Every 90 days, the District Nurse shall consult with the appropriate facility staff and review treatment record(s) and other Level of Care (acuity) documentation related to the member's condition and progress.

Refer to the Division's Medical Policy Chapter 1210, for additional information regarding services provided in these settings.

C. Documentation

1. The initial referral by the Support Coordinator for a nursing assessment shall be included as part of the member's case file. In addition, the date the referral was sent to HCS along with any communication regarding the referral shall be documented in the member's Focus progress notes.

2. All assessments and monitoring re-assessments completed by the District Nurse shall be sent to the Support Coordinator and included as part of the member's case file.

3. The District Nurse shall ensure the signed Plan of Care received from the Division contracted nursing agency is included in the member's case file and documented in the Focus progress notes.

4. If the member is residing in a Skilled Nursing Facility (SNF), the SNF Uniform Assessment Tool (aka acuity tool) completed by the District Nurse shall be included in the member's case file.

5. If the member is residing in an institutional setting, the member's progress related to specific skilled nursing needs, including compliance related to prescribed treatments, shall be documented in the member's case file.

Discussions regarding the member's needs, including action items and services identified to coordinate and meet the member's needs, shall be incorporated into the member's Planning Document, and documented in the member's file.

1620-L CASE FILE DOCUMENTATION

REVISION DATE: 11/8/2023, 3/9/2022
EFFECTIVE DATE: September 8, 2021
REFERENCES: 45 CFR Part 164, 42 CFR Part 2, A.R.S. § 12-2297, AMPM 1620-L, AMPM Exhibit 1620-3,, Division Medical Policy 680-C, 1620-B, and 1620-D

PURPOSE

This policy establishes the Division's requirements to maintain complete and accurate documentation in the Member's case file that details coordination of care activities. These requirements also ensure the Division's actions provide Members with effective and efficient coordination of care.

DEFINITIONS

1. "Health Insurance Portability and Accountability Act (HIPAA)" means the Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

2. "Member" means the same as "client" as defined in A.R.S. § 36-551.

3. "Planning Document'' means a written plan developed through

an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.

5. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

6. "Specialized Services" means these are recommended services resulting from the PASRR Level II evaluation that are beyond those normally provided and included in the nursing facility (NF) NF daily rate. These services have three key characteristics:

    a. They are individualized needs related to a person's Intellectual Disability and/or a related condition, as identified in the Level II evaluation.

b. They are provided to the individual during their residency in the NF.

c. They exceed the services a NF typically provides under its daily rate. Recall that PASRR applies to any individual applying for admission to a Medicaid-certified nursing facility, regardless of insurance type.

POLICY

A. MEMBER ELECTRONIC AND PAPER RECORDS

1. The Division shall maintain a system of record keeping that maintains Member case file documentation in a secure and organized manner.

2. The Division shall utilize electronic systems to track and maintain Member case files.

   a. The Division shall maintain the system which includes:

      i. The management of information regarding Member demographics, services plans, authorization, vendor calls, and claims.

ii. Documenting the beginning and ending dates of services listed on the Planning Document, and

iii. The renewal of services and the number of units authorized for services.

iv. Documentation of all actions related to the Member's coordination of care with the Division, the Division's contractors, community partners, or others involved in the Member's care unless otherwise restricted.

b. The Division shall maintain the system which stores the Member case file electronically.

3. The Division shall provide AHCCCS printed documents when requested by AHCCCS.

4. The Division shall adhere to the federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and for the Confidentiality of Substance Use Disorder Patient Records found at 42 CFR Part 2.

5. The Division shall keep Member case files secured with controlled access by authorized individuals.

a. The Division shall store paper documents in locked file cabinets or behind locked doors after normal business hours and in compliance with department record keeping confidentiality policies.

b. The Division shall ensure the integrity of electronic documentation by having safeguards like firewalls and encryption protocols for digital documents.

B. DIVISION STAFF RESPONSIBILITIES

1. Division staff shall be responsible for maintaining complete and comprehensive case file documentation for each Member.

2. Division staff shall provide documentation that is complete, accurate, timely, and reflective of the Member's programmatic, social, medical, behavioral, developmental, educational, or vocational status.

3. Division staff shall create all documentation in a professional, factual, and objective manner.

4. Division staff shall update the Focus Progress Notes to document Member information changes and completed activities.

5. Division staff shall indicate in the Focus Progress notes the name of the author and document all interactions with and about the Member, the services and supports the Member is receiving, and the status of the Member's case unless otherwise restricted.

6. Division staff shall maintain the Member case file information to the extent, and in such detail, as specified in A.R.S. § 12-2297.

C. SUPPORT COORDINATION RESPONSIBILITIES

1. The Support Coordinator shall, based on the Member's circumstances, document in the Focus Progress Notes, the following care coordination activities:

   a. Documentation of all actions related to providing the Member with coordination of care and benefits, unless otherwise restricted.

   b. Team discussion regarding the need for a new or revised Behavioral Plan (BP) needed for Home and Community Based Services (HCBS) provided by an independent provider or Qualified Vendor in response to the use of Emergency Measures two or more times within a 30-day period, or with an identifiable pattern.

c. The results of screening for side effects of behavioral modifying medication and tardive dyskinesia.

d. Referrals for Behavioral Health services, a Care Manager, a Behavioral Health Advocate. Referrals for community services.

e. The Support Coordinator's response to notifications of Member Emergency Room visits and Crisis Contacts.

f. Documentation of the outcome of initial and quarterly consultations with the Behavioral Health Professional.

g. Support Coordinator action regarding referrals to Health Care Services (HCS), Member hospitalization and discharge planning, and the use of Emergency Alert Systems.

h. Any other activities or correspondents that may be related to Member care coordination.

2. The Support Coordinator shall include and maintain the following in the Member case files.

a. Member demographic information, including residence address and telephone number, and the emergency contact

person and his/her telephone number.

b. Identification of the Member's primary care provider (PCP),

c. For Members residing in a nursing facility, the AHCCCS Uniform Assessment Tool (UAT)/(acuity tool) is completed at least annually by a Nurse, see AMPM Exhibit 1620-3.

d. The Member Level of Care Tool for all Members residing in a community-based setting at least annually by the Support Coordinator and when the circumstances of the Member changes.

e. Information from the Planning Meetings that addresses the following:

   i. Member's ability to be present and participate in the Planning Meeting and any needed accommodations for the Member to participate in the Planning Meeting.

   ii. Documentation describing the Member's involvement in their planning meeting including the support coordinator's interactions with the Member.

iii. Member's current medical, functional, and behavioral health status, including strengths and needs, in accordance with the requirements outlined in Division Medical Policy 1620-B,

iv. The appropriateness of the Member's current residential setting and services in meeting his or her needs, including the potential of the Member to move to a less restrictive setting.

v. The cost effectiveness of ALTCS services being provided,

vi. Identification of family, an informal support system, and community resources and their availability and willingness to assist the Member as uncompensated caregivers, including barriers to assistance,

vii. Identification of service issues and unmet needs, an action plan to address needs, and documentation of timely follow-up and resolution,

viii. A detailed description of the Member's objectives and

services for each behavioral health agency providing services to the Member,

ix. Documentation of the Member's progress toward identified goals and any strategies toward overcoming barriers as outlined in Division Medical Policy 1620-B,

x. Environmental details, which may include any safety concerns in the Member's home, or other special needs.

xi. Behavioral Plan developed by the Member's team in accordance with Article 9. See Behavioral Supports Manual Chapter 700.

xii. Documentation of all actions and information that is relevant to providing the Member with coordination of care unless otherwise restricted.

f. Copies of the Member's signed Cost Effectiveness Studies (CES) Worksheets, placement history, Planning Documents, and service authorizations.

g. Copies of the signed Planning Documents that are signed by the Responsible Person at each planning meeting.

h. A copy of the HCBS Member Needs Assessment (Form DDD-2039A) completed for all Members receiving Attendant Care, Homemaker, or Habilitation services that indicates how the service hours were assessed and which portions of care, if any, are provided by the Member's informal support system.

i. A copy of the Contingency/Backup Plan (Form DDD-2113A) and other documentation that indicates the Responsible Person has been advised regarding how to report unplanned gaps in services provided by an Independent Provider (IP) as outlined in Division Medical Policy 1620-D.

j. A copy of the Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) for any Member choosing to have his or her spouse as the paid caregiver, both before that service arrangement is initiated and annually to indicate the Member's continued choice for this option,

k. A copy of the Managed Risk Agreement (Form DDD-1530A), when indicated for the Member, that identifies potential risks associated with service or placement decisions the Responsible Person has madeor other risks identified whereby a Managed Risk Agreement was completed.

l. Notices of Adverse Benefit Determination along with any adjudication or decisions sent to the Responsible Person regarding denial or changes of services,

m. Member-specific correspondence

n. Evaluation and other records demonstrating eligibility and redeterminations of eligibility.

o. Physician’s orders for medical services and equipment,

p. Documentation that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and PASRR Level II evaluation, if applicable, have been completed for Members in nursing facility placements. A copy of the PASRR Level II evaluation, if applicable, must also be

retained in the Member's case file. For further details regarding PASRR, see Division Medical Policy 680-C.

q. Documentation of recommended specialized services, as applicable, shall be coordinated and documented in the Member case file to ensure the provision of specialized services to the Member. For further details regarding this, see Division Medical Policy 680-C.

r. Provider evaluations and assessments or progress reports ,

s. Notifications of services not provided as scheduled and documentation of any follow-up conducted to ensure that Member's needs are met,

t. Documentation of the initial and quarterly discussion with a qualified behavioral health professional, when applicable,

u. All forms and documentation as required by the Division to provide the Member with coordination of care unless otherwise restricted.

3. The Support Coordinator shall include in the initial on-site

Planning for Members receiving Home and Community Based Services (HCBS already in place at the time of ALTCS enrollment) an assessment of the medical necessity and cost effectiveness of those services and a service plan that indicates which Prior Period Coverage (PPC) services will be retroactively authorized by the Division. For further information, see Division Operation Policy 302.

D. ENSURING MEMBER SPECIFIC PROGRESS NOTES

1. Division staff shall not cut and paste, or otherwise copy, Member correspondence into the Member's file.
2. Division staff shall not use templates, or other standardized templates, that are not specific to the Member.
3. Division staff shall not rely on system generated progress notes as the primary source of information when documenting in the Focus progress notes.

1620-N SERVICE CLOSURE AND CASE CLOSURE

EFFECTIVE DATE: September 8, 2021
REFERENCES: AMPM 1620-N

PURPOSE

The purpose of this policy is to identify the reasons an ALTCS covered service may be ended and to specify the steps needed when case closure should be pursued for a member currently enrolled with the Division.

DEFINITIONS

Arizona Health Care Cost Containment System (AHCCCS) – The state agency that is responsible for determining eligibility for Arizona Long Term Care Services (ALTCS).

Notice of Adverse Benefit Determination (NOA) – The written notice to the member regarding an Adverse Benefit Determination.

Office of Administrative Review (OAR) – The unit within the Division of Developmental Disabilities that processes and ensures adjudication of appeals and grievances.

POLICY

Service Closures

A. Closure of a member's service(s) may occur for various reasons, including, but not limited to:

1. The member is no longer ALTCS eligible as determined by AHCCCS.

    a. If the member has been determined ineligible for ALTCS, the member/responsible person will be informed of this action and the reason(s), in writing, by AHCCCS. This notification will provide information about the member's rights regarding that decision.

    b. The Focus task is the Division's "official" notification from AHCCCS that a change in the member's ALTCS eligibility has occurred. Thus, it is critical Support Coordinators review Focus tasks daily and take immediate action regarding services if notified that a member has been disenrolled from ALTCS.

2. The Support Coordinator has assessed a service as no longer necessary.

3. The Therapist, Division District Nurse or other clinician determines the goals have been met, the service is no longer medically necessary, or cost effective.

4. Physician has determined that a service is no longer necessary.

5. The member/responsible person requests discontinuance of a service.

6. The member/responsible person refuses to meet to re-assess the continuation of services currently authorized by the Division.

7. For members who are AzEIP eligible, non-ALTCS covered services shall be ended when the member ages out of the AzEIP program.

Case Closure

A. Closure of the member's eligibility with the Division may occur for a variety of reasons, including but not limited to the following situations:

1. The member has passed away.

2. The member moves out of state. If the member is a minor child, residency requirements are dependent upon the residency of the custodial parent.

3. The member/responsible person requests the member's case to be closed with the Division. If the member is ALTCS eligible and wishes to withdraw from the Division, the member/responsible person must first withdraw from ALTCS.

4. The member/responsible person has requested a voluntary withdrawal from the ALTCS program.

   a. A member who is disenrolling from ALTCS will generally remain enrolled through the end of the month in which the eligibility is terminated.

   b. If the member voluntarily withdraws and wants ALTCS benefits to stop immediately, the disenrollment will be effective with the processing of the withdrawal by AHCCCS.

   c. The Support Coordinator shall consult with his/her supervisor to determine if the member's eligibility shall be closed or placed in inactive status (e.g., involvement of protective service agencies, member likely to change his/her mind, request of the member/responsible person, etc.).

5. The member is no longer eligible for the Division. See the Division's Eligibility Manual for further details regarding eligibility criteria and redetermination requirements.

6. The member reaches the age of eighteen and does not wish to reapply for continuation of eligibility with the Division.

7. Contact has been lost with member and their responsible person. This includes members who have moved from the previous residence and the SC is unable to locate.

a. All communication methods available to the Support Coordinator (i.e., regular letter, certified letter/return receipt requested, telephone, email, text) have been unsuccessful.

b. Prior to pursuing case closure, the Support Coordinator shall consult with their Supervisor and ensure due diligence has been made to make contact and determine why attempts were unsuccessful.

c. If the member is ALTCS eligible, the Support Coordination shall continue attempts to schedule a meeting.

d. AHCCCS will not disenroll the member from the ALTCS program if they are able to contact the member/responsible person.

B. The member continues to be the responsibility of the Division until the member's disenrollment is processed by AHCCCS and the Division is notified via AHCCCS roster. The Support Coordinator shall be notified via a Focus task of the member's disenrollment.

1. Members are eligible to receive medically necessary services through their ALTCS disenrollment date.

2. The Support Coordination shall comply with all AHCCCS requirements, including scheduling and conducting Planning meetings until the member has been disenrolled from ALTCS.

C. For members who are DD only or Targeted Support Coordination eligible the member can be disenrolled at any time.

Notices

A. Notice of Adverse Benefit Action – If a previously authorized service is terminated, suspended, or reduced as no longer medically necessary or cost effective for an ALTCS eligible member, the member/responsible person shall be given a Notice of Adverse Benefit Determination (NOA) regarding the plan to discontinue the service. The NOA shall contain information about the member/responsible person's rights regarding the decision. A NOA is not required if the member/responsible person agrees to the reduction or termination. See Division Operations Policy 414 for additional details regarding NOA requirements.

B. No Show Letter (DDD-2066A) - If a member has a planning meeting scheduled, and does not show, and does not attempt to contact the Division in advance of the meeting to reschedule, then the Support Coordinator shall send a DDD-2066A No Show Letter by regular and certified mail.

C. Loss of Contact Letter (DDD-2065A) – If a member enrolled with the Division cannot be located, then the Support Coordinator shall send a DDD-2065A Loss of Contact Letter via certified and regular mail. If there is no response within required timelines, a Notice of DDD Closure shall be pursued.

D. Notice of DDD Closure (DDD-2028) – When a member is no longer eligible for the Division or chooses to be disenrolled from the Division.

E. The Office of Administrative Review

1. Except in a situation in which a member has passed away, the Division will send a notice to the member/responsible person advising that eligibility for the Division is ended. In addition, the Division will send a Notice of Action (NOA) when an ALTCS covered service is being terminated, suspended, or reduced. The notice shall include the right to request an Administrative Review along with the process for requesting an Administrative Review.

2. The Office of Administrative Review (OAR) will notify the Support Coordinator when a request for Administrative Review is received from the member/responsible person.

3. The Support Coordinator/Supervisor can also contact OAR if there are questions regarding the status of the Administrative Review.

F. The Electronic Member Change Report (eMCR) is the Division's notification to AHCCCS for ALTCS members when there is a change in the member's eligibility for the Division. The AHCCCS eMCR Guidelines provides instructions regarding completing an eMCR on the AHCCCS website.

1. Upon notification of the member's passing, the Support Coordinator shall immediately complete an eMCR.

2. If the member/responsible person requests voluntary withdrawal, the DDD-2083A shall be completed and signed by the member/responsible person. The voluntary withdrawal form shall be attached to the eMCR.

3. When an ALTCS eligible member has been redetermined no longer eligible for the Division, an eMCR shall not be completed until all appeal timeframes have been exhausted. The Support Coordinator/Supervisor can contact OAR if there are any questions regarding the status of any appeals.

a. Once all appeal timeframes have been exhausted, the Support Coordinator shall complete an eMCR requesting a PAS Reassessment. AHCCCS will then evaluate the member for the ALTCS/Elderly Physically Disabled (EPD) program.

b. If the member is determined eligible for the ALTCS/EPD program, the Support Coordinator shall work with the Division's Transition Coordinator to coordinate a transfer between the Division and the ALTCS/EPD Program Contractor. The purpose is to ensure a smooth transition from the Division to the other ALTCS program contractor. Refer to Division Medical Policy 520 for additional information regarding member transitions.

c. If a member is disenrolled from ALTCS, but remains eligible for AHCCCS benefits, the Support Coordinator shall direct the

member/responsible person to the AHCCCS website for information regarding available AHCCCS Complete Care (ACC) Contractors and encourage the member to convey their choice of health plans to the AHCCCS Communication Center at 1-800-962-6690.

Documentation

A. All attempts to contact the member/responsible person and actions taken shall be documented in the member's case record.

B. When the reason for termination is the member's death, the Support Coordinator shall end date the service authorization(s) with the date of death.

C. Upon notification from AHCCCS that the member has been disenrolled from ALTCS, the Support Coordinator shall "end date" the FOCUS authorizations. The Support Coordinator is responsible for notifying service providers when a service has ended, or the member is no longer eligible. Continuation of residential services using state funds shall be prior authorized by the District Program Manager and include a plan for re-applying for ALTCS.

D. The Support Coordinator shall ensure all notices along with any Administrative or Judicial resolution are uploaded into the member's case record in OnBase. All member records shall be stored in accordance with Division Record Retention Policies. For further details, see Division Operations Policy 6001-I and Division Medical Policy 1620-L.

E. The Support Coordinator shall provide the member/responsible person community referral information on available services and resources to meet the needs of members who are no longer eligible for ALTCS and/or the Division. This assistance shall be included as part of the member's case record.

F. The Focus progress notes shall reflect service and case closure activity, including but not limited to:

1. Reason for closure,

2. Member's status at the time of the closures, and

3. Referrals to community resources if the member is no longer ALTCS eligible.

G. The Support Coordinator shall ensure the member's record is complete prior to closing the member's case. This includes, but not limited to, ensuring the member records have been uploaded to OnBase (e.g., communication on behalf of the member, Planning Documents, and other records) and Focus progress notes are updated to reflect steps taken to close the record and the reason for closure.

1620-O ABUSE, NEGLECT, AND EXPLOITATION REPORTING STANDARD

EFFECTIVE DATE: October 6, 2021

REFERENCES: A.R.S. §§ 36-561(B), 13-3620, 46-454, 46-451. Division Operations Manual Chapters 6002-B, 6002-C, and 6002-G

DEFINITIONS

Abuse - Any of the following is abuse:

1. Intentional infliction of physical harm
2. Injury caused by negligent acts or omissions
3. Unreasonable confinement or unlawful imprisonment
4. Sexual abuse or sexual assault

Abusive Treatment - Any of the following is abusive treatment:

1. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or sexual abuse.
2. Verbal/Emotional abuse which includes ridiculing or demeaning a member, making derogatory remarks to a member or cursing directed towards a member.
3. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Planning Document and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Adult Protective Services (APS) - A program within the Arizona Department of Economic Security that investigates allegations and provides service referrals to protect vulnerable adults from abuse, neglect, or exploitation.

Arizona Department of Child Safety (DCS) - The department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.
2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Child, Youth, or Juvenile - A member who is under the age of eighteen years.

Exploitation - The illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity - An impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

Neglect - The deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating or other services necessary to maintain a member's minimum physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty, abandoning the workstation, or failure to carry out a prescribed treatment plan.

Neglect of a child includes the substantial risk of harm due to inability or unwillingness of a parent, guardian, or custodian, to care for the child. This includes the inability or unwillingness to provide supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

Physical Injury - The impairment of physical condition, including, but not limited to any of the following: skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

Serious Physical Injury - A physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, serious impairment of health or loss, or protracted impairment of the function of any bodily organ or limb.

Sexual Abuse Any inappropriate interactions of a sexual nature toward or solicited from a member with developmental disabilities.

Vulnerable Adult - A member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect, or exploitation by others because of a mental or physical impairment. This includes an incapacitated person as specified in A.R.S. § 14-5101.

POLICY

As designated by law, medical professionals, psychologists, social workers, Support Coordinators, peace officers, and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters. Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred must report such information immediately to a peace officer or protection services worker, (i.e., DES/Adult Protective Services (APS), Department of Child Safety, Tribal Social Services).

A. Reporting to the Arizona Department of Child Safety (DCS)

1. The Support Coordinator is a mandatory reporter. The Support Coordinator must immediately report to the Department of Child Safety (DCS) when they suspect abuse or neglect. Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations, and follow-up as required.

2. Reports made regarding American Indians will be in accordance with tribal procedures. Reports are to be made as soon as possible but no later than 24 hours of becoming aware of the concern. Reports shall include the following information:

   a. The names and addresses of the minor and his/her parents or person or persons having custody of such minor.

   b. The minor's age, and the nature and extent of his/her injuries, or physical neglect, including any evidence of previous injuries or physical neglect.

   c. Any other information that such a person believes might be helpful in establishing the cause of the injury or physical neglect.

3. The list of persons with a duty to report a reasonable belief that a minor has been the victim of abuse or neglect is expanded to include any person who is employed as the immediate or next higher-level supervisor to, or administrator of, a person who has a duty to report (other than the child's parent or guardian) and who develops the reasonable belief in the course of the supervisor's or administrator's employment. If the supervisor or administrator reasonably believes that the report has been made by the person with a duty to report, the supervisor or administrator is not required to report.

4. When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Call Report (DDD-1746A-FORFF) and submit to their District's Incident Report email address. The Incident Call Report shall indicate the date and time DCS was notified.

   Additionally, if DCS notifies the Support Coordinator of alleged abuse or neglect report made by other than Division personnel, the Support Coordinator shall complete and submit an Incident Call Report.

5. It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. If, after an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

B. Working with the Arizona Department of Child Safety (DCS)

1. The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

2. Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

3. The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff must immediately pursue the steps necessary to resolve the issues.

4. The Support Coordinator shall collaborate with DCS Specialist and provide them with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings.

C. Reporting to Adult Protective Services (APS)

1. In accordance with A.R.S. §46-454, as a mandatory reporter, the Support Coordinator, or other Division staff, shall immediately report any suspicions/allegations of abuse, neglect, or exploitation of an adult member to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements below. The person:

   a. Is 18 years of age or older

   b. Is a vulnerable adult as defined in A.R.S. § 46-451.

2. Reports made to APS shall contain:

   a. The names and addresses of the adult and any persons having control or custody of the adult, if known

   b. The adult's age, and the nature, and extent of his/her incapacity or vulnerability

   c. The nature, and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property

   d. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

3. When the Support Coordinator reports alleged abuse or neglect to APS, the Support Coordinator shall complete an Incident Call Report (Form DDD-1746A-FORFF) and submit to their District's Incident Report email address. The Incident Call Report shall indicate the date and time APS was notified.

4. When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together will with the Support Coordinator or other Division staff as appropriate. The APS worker will remain involved until the abuse or problem situation has been resolved.

5. When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS and notification of the fact-finding process. DES/DDD staff, as appropriate, will conduct a fact-find to determine programmatic and contract compliance issues.

D. Working with Adult Protective Services (APS)

1. The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

2. Whenever possible, the Support Coordinator shall discuss the situation with the APS worker and provide any relevant facts and important historical information.

3. The Support Coordinator shall elevate to their supervisor if there are additional concerns that cannot be resolved at their level.

4. The Support Coordinator shall collaborate with APS to ensure the member's needs are met. This includes but is not limited to identifying and obtaining behavioral health and medical services, and community resources as applicable. Some examples: identification of a Representative Payee, transportation to medical appointments, and a referral to HUD housing.

E. Quality of Care Concerns (QOC)

1. The Support Coordinator shall cooperate with and complete any follow up necessary for the Division to resolve a QOC.

1621 ENHANCED STAFFING RATIOS

EFFECTIVE DATE: March 20, 2024
REFERENCES: A.R.S. 42 CFR 438.400, A.A.C. R9-22-702, ACOM Policy 414

PURPOSE

This policy outlines the Division's requirements when assessing for and approving Enhanced Staffing Ratios (ESR) for Members who may need increased support in a specific setting.

DEFINITIONS

1. "Enhanced Staffing Ratio" or "ESR" means the number of paid supports, greater than currently provided to the Member in the service setting and ensures the Member's health, safety, and emotional, spiritual, and physical well-being.

2. "Member" means the same as "client" as defined in A.R.S. § 36-551.

3. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences

for the delivery of such services and supports.

4. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems..

5. "Reduction Plan" means a plan, that is outlined in the Planning Document, to decrease the service frequency, duration, or level of service and agreed to in writing by the Responsible Person.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

8. "Staffing Ratio" means the number of Direct Care Workers that support a Member in a specific service setting.

POLICY

A. ENHANCED STAFFING RATIOS (ESR)

1. The Support Coordinator shall assess for and approve an ESR when:

   a. The Member has been determined to need increased supervision or increased care to provide for personal care, medical needs, or behavioral supports in a specific setting, and

   b. Requested by the Responsible Person.

2. The Support Coordinator shall assess and approve an ESR to support the Member in the least restrictive way possible and consider the Member's basic human rights to participate in the Member's daily activities. For additional information on a Member's basic human rights, refer to A.A.C. R9-22-702.

3. The Support Coordinator shall assess and document the request

for an ESR in the Planning Document.

4. The Support Coordinator shall request a Nursing assessment when a skilled nursing need is identified during the assessment for an ESR. Refer to Division Medical Policy 1240-G, Exhibit 1.

5. The Planning Team shall develop a Reduction Plan that clearly identify proactive and preventative strategies that will be used to reduce the need for an ESR.

    a. The support outlined in the Reduction Plan leads to personal growth and independence.

    b. The plan clearly outlines parameters to identify when the ESR needs to be reduced or is no longer needed.

    c. The Reduction Plan is documented in the Planning Document and Behavioral Plan as applicable.

    d. The Reduction Plan will include outcomes in the Planning Document to decrease or replace behaviors that require an ESR.

6. The Division shall require the Planning Team to provide

documentation that supports the Member's need for an ESR.

B. ASSESSING FOR PERSONAL CARE AND MEDICAL NEEDS

1. The Planning Team shall consider an ESR for a Member when the Member has personal care and medical needs that cannot be met in a standard Staffing Ratio.

2. The Support Coordinator shall consider the following when assessing the need for an ESR due to a Member's personal care and medical needs that impacts the Member's ability to complete activities of daily living.

    a. Seizures requiring rescue medications, emergency intervention, and close monitoring.

    b. Frequent Falling – A pattern of recent multiple falls in the last 60 days, which require staff to monitor the Member when standing or walking.

    c. Physical support needed for all personal care.

    d. Visual impairment or blindness that requires frequent intervention to support the Member in participating in

planned outcomes or activities.

e. Documentation of a medical diagnosis that impacts the Member's ability to complete activities of daily living;

f. Other medical or personal care needs that require frequent monitoring or interventions as determined by the Division.

C. ASSESSING FOR BEHAVIORAL NEEDS

1. The Support Coordinator shall consider an ESR for a Member when the Member has behavioral health needs that cannot be met in a standard Staffing Ratio.

2. The Support Coordinator shall consider the frequency, duration, and intensity of the Member's behaviors when assessing for an ESR for behavioral health needs.

3. The Support Coordinator shall consider the following when assessing the need for an ESR due to the Member's behaviors that pose a significant health and safety concern or a risk to themselves or others:

a. Documentation of behaviors placing the Member at risk or

injury to self or others;

b. Documentation that the Member is receiving or pursuing services through a behavioral health agency or professional;

c. Habilitation outcomes to decrease unsafe behaviors have been unsuccessful in the past;

d. Documentation from a medical professional describing a severe medical need or physical condition that would place the member at risk;

e. Documentation indicating a loss of skills that are unlikely to be regained;

f. Documentation of the Member leaving a situation or environment neither notifying nor receiving permission from the appropriate individual;

g. The Member is at risk to self or others when alone in the community or may be unable to return safely;

h. The Member cannot attend a typical day program because the Member's health and safety would be at risk or the

health and safety of other individuals may be at risk;

i. Documentation of the presence of confusion or disorientation;

j. Documentation that the member is receiving an ESR at school or daycare; and

k. A Member who has an identified wandering risk or has unsafe behaviors must have received, or will receive habilitation to minimize the need for an ESR;

l. Other behavioral health needs as determined by the Division.

D. DENIALS, TERMINATIONS, REDUCTIONS, AND SUSPENSIONS

If the Responsible Person disagrees with the assessment, the Division shall provide the Responsible Person with a Notice of Adverse Benefit Determination when the request for an ESR has been denied, terminated, reduced, or suspended. Refer to Division Operations Policy 414 for additional information on Notice of Adverse Benefit Determinations.

1630 ADMINISTRATIVE STANDARDS

REVISION DATE: 7/26/23
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. §441.555c, § 36-551, AMPM Chapter 1600, Division Medical Policy Chapter 1610, Division Medical Policy 680-C

PURPOSE

This policy establishes administrative responsibilities related to Support Coordination for Division Members who are eligible for the Arizona Long Term Care System (ALTCS) or Targeted Support Coordination (TSC).

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

3. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs

through communication and available resources to promote quality, cost-effective outcomes.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

5. "Targeted Support Coordination (TSC)" means a covered service provided by the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to Members with Developmental Disabilities (DD) who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program

POLICY

A. SUPPORT COORDINATOR QUALIFICATIONS

1. The Division shall hire individuals as Support Coordinators that shall:

   a. Be a licensed, registered nurse;

   b. Have a Bachelor's or Master's degree in Social Work;

   c. Have a degree in Psychology, Special Education, or

Counseling and at least one year of experience in case management;

d. Have two years experience in providing case management services to:

i. Persons who are elderly, and/or

ii. Persons with physical or developmental disabilities and/or persons who have been determined to have a Serious Mental Illness (SMI).

B. DOCUMENTATION

1. The Division shall use the following AHCCCS standardized forms:

a. Uniform Assessment Tool: Division District Nurse utilizes for Members residing in a Skilled Nursing Facility (SNF).

b. Person-Centered Service Plan (Form DDD-2089A) , for Members aged 3 years and up.

C. TRAINING

1. The Division shall maintain documentation of training dates and staff attendance, and copies of materials used, that are maintained for record-keeping.

2. The Division shall provide uniform training to all Support Coordinators including formal training classes and mentoring-type opportunities for newly hired Support Coordinators.

3. The Division shall provide newly hired Support Coordinators with an orientation and training in the following areas:

   a. The role of the Support Coordinator in utilizing a Member-centered approach to Arizona Long Term Care System (ALTCS) Support Coordination, including maximizing the role of the Member and their family in decision-making and service planning;

   b. The principle of most integrated, least restrictive settings for service delivery;

   c. Recognizing Member rights and responsibilities;

   d. Adherence to Support Coordination responsibilities as outlined in Division Medical Policy 1610.;

   e. Support Coordination procedures specific to the Division;

   f. An overview of the continuum of AHCCCS/ALTCS program

including available service delivery options, service settings, and service restrictions or limitations;

g. The Division provider network by location, service type and capacity, including information about community resources for non-ALTCS covered services.

h. Information on local resources for housing, education, and employment services/programs that could help Members gain greater self-sufficiency in the areas.

i. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, and/or exploitation;

j. General medical information, such as symptoms, treatments, and medications, common to the Members served by the Division.

k. General social service information, such as family dynamics, care contracting, dealing with difficult situations, and risk management.

l. Behavioral health information, including identification of Member's behavioral health needs, covered behavioral

health services and how to access those services within the Division's network, and the requirements for initial and quarterly behavioral health consultations.

m. Support Coordination responsibilities, including processes for making referrals to the Member's behavioral health provider for SMI determination and standards related to the provision of services for Members determined to have an SMI.

n. The Pre-Admission Screening and Resident Review (PASRR) process as outlined in Division Medical Policy 680-C.

o. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Members under the age of 21,

p. Member specific data from Focus is transmitted to AHCCCS bi-weekly and retained in the AHCCCS Pre-Paid Medical Management Information Systems/Client Assessment Tracking System (PMMIS/CATS) with the exception of Cost-Effective Studies which are directly entered into AHCCCS PMMIS.

q. Responsibilities related to monitoring for and reporting fraud, waste, and abuse.

r. Information and resources related to caregiver stress and burnout.

s. End-of-life person-centered planning, services, and supports including covered services and how to access those services within the Member's AHCCCS health plans.

6. The Division shall provide all Support Coordinators with regular ongoing training on topics relevant to the population served by the Division, in addition to the review of areas covered during orientation as outlined below:

a. Policy updates and new procedures.

b. Refresher training identified from internal monitoring reviews.

c. Interviewing, observation, and assessment skills.

d. Cultural competency skills.

e. Member rights.

f. Physical/behavioral health conditions.

g. Medications – side effects, contraindications, poly-pharmacy issues.

h. Article 9, and other relevant training.

7. The Division shall maintain staff who are designated as the expert(s) on housing, education, health care services, and employment issues and resources within the Division's service area. These staff shall be available to assist Support Coordinators with up-to-date information designed to aid Members in making informed decisions about their independent living options.

D. CASELOAD MANAGEMENT

1. The Division shall provide adequate numbers of qualified and trained Support Coordinators to meet the needs of enrolled Members.

2. The Division shall maintain protocols to ensure newly enrolled ALTCS Members are assigned to a Support Coordinator immediately upon enrollment.

E. ACCESSIBILITY

1. The Division shall provide the Responsible Person with adequate information to be able to contact the Support Coordinator or DDD office for assistance, including what to do in cases of emergencies and/or after hours.

2. The Division shall provide back-up Support Coordinators to the Responsible Person to contact when their primary Support Coordinator is unavailable.

3. The Division shall ensure the Responsible Person and providers are called back in a timely manner when messages are left for Support Coordinators.

F. TIME MANAGEMENT

1. The Division shall ensure that Support Coordinators are not assigned duties unrelated to Member-specific Support Coordination for more than 10% of their time if they carry a full caseload.

G. CONFLICT OF INTEREST

1. The Division shall ensure Support Coordinators are not:

a. Related by blood or marriage to a Member, or any paid caregiver of a Member, on their caseload;

b. Financially responsible for a Member on their caseload;

c. Empowered to make financial or health-related decisions on behalf of a Member on their caseload;

d. In a position to financially benefit from the provision of services to a Member on their caseload;

e. Providers of ALTCS services for any Member on their caseload;

f. Individuals who have an interest in, or are employed by, a provider of ALTCS services for any Member on their caseload.

2. Exceptions to the above shall be made under limited circumstances as described under 42 CFR 441.555c with prior approval from AHCCCS Administration.

H. SUPERVISION

1. The Division shall ensure a supervisor-to-Support Coordinator ratio is established that is conducive to a sound support

structure for Support Coordinators.

2. The Division shall ensure supervisors have adequate time to train and review the work of newly hired Support Coordinators and provide support and guidance to established Support Coordinators.

I. MONITORING

1. The Division shall ensure a system of internal monitoring of the Support Coordination program, including case file reviews and reviews of the consistency of Member assessments and service authorizations, has been established and applied, at a minimum, on a quarterly basis.

    a. The Division shall monitor the implementation of the ALTCS and Targeted Support Coordination (TSC) programs through a variety of tools. Data gathered through Focus and other systems are analyzed to ensure compliance with AHCCCS and Division standards. Support Coordination caseload ratios and other issues that may impact the timely delivery of services in meeting Member needs shall also be evaluated.

b. The Division shall utilize a case file review process to monitor the Support Coordination program.

i. Support Coordination: Supervisors, or designee, shall complete case file reviews on a quarterly basis to monitor the Division's compliance with its policies and procedures and contractual requirements with AHCCCS. The supervisor shall use this opportunity to provide feedback to the Support Coordinator regarding their work performance and provide training regarding various requirements of the ALTCS and TSC programs. The supervisor shall also use this opportunity to identify any issues and correct them for that case file and other case files on the Support Coordinator's caseload.

ii. The Division shall utilizecase file reviews and a survey to determine the Responsible Person's satisfaction with the services and supports received through the Division. If concerns are identified, The Support Coordinator's supervisor shalldevelop a plan to resolve any issues brought forth by the

Responsible Person.

iii. For questions below 95% compliance, the Division shall analyze the responses, at both a district and a statewide level, to determine root cause(s) and shall take appropriate action to improve compliance, including developing an improvement plan, as needed.

c. Support Coordination management shall:

i. Identify trends within their units and take appropriate steps.

ii. Trend the quarterly results to determine if additional action steps are needed to improve the District/Division's compliance with various requirements.

d. The Division shall monitor the timeliness of ALTCS planning meetings and TSC contacts in compliance with Division Medical Policy Manual Chapter 1600.

e. Support Coordination shall conduct Inter-Rater Reliability (IRR) reviews, on a quarterly basis, to ensure the

consistency of Member assessments and service authorizations.

f. Improvement plans shall be developed, as needed, to foster continuous improvement. The Division's leadership shall oversee these efforts.

g. The Division shall document and make available to AHCCCS, upon request, the results from this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies.

J. INTER-DEPARTMENTAL COORDINATION

1. The Division shall establish and implement mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with Medical Management (MM) and Quality Management (QM).

2. The Division's Medical Management Medical Director shall be available as a resource to Support Coordination and shall be advised of medical management issues as needed.

K. REPORTING REQUIREMENTS

1. The Division shall submit a Support Coordination Annual Plan to AHCCCS, on or before December 15th.

   a. The plan shall address how the Division shall implement and monitor the Support Coordination and administrative standards outlined in AMPM Chapter 1600, including specialized caseloads.

   b. An evaluation of the Division's Support Coordination Plan from the previous year is also included in the plan, highlighting lessons learned and strategies for improvement.

Signature of Chief Medical Officer: Anthony Dekker (Jul 21, 2023 11:58 PDT)
Anthony Dekker, D.O.

1640 TARGETED SUPPORT COORDINATION STANDARDS

REVISION DATE: 1/3/2024, 7/6/2021
REVIEW DATE: 8/18/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: AHCCCS AMPM Chapter 1640; A.R.S. § 36-551, Division Medical Policy 1650 DD Only Eligible

PURPOSE:

This policy outlines requirements related to Support Coordination for Members determined to be eligible for Targeted Support Coordination including Support Coordinator responsibilities, level of contact requirements, documentation standards, and Division responsibilities.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.

5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.

6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and

evaluates options and services to meet an individual's needs through communication and available supports to promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

8. "Targeted Support Coordination" or "TSC" means a covered service provided by the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to members with developmental disabilities who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the Arizona Long Term Care System (ALTCS) program.

9. "Title XIX" means the section of the Social Security Act which describes the Medicaid program's coverage for eligible persons, (i.e., medically indigent). Title 19 benefits are provided through the Medicaid federal entitlement program; benefits are delivered in Arizona through the Arizona Health Care Cost Containment System (AHCCCS). This includes individuals who receive Supplemental Security Income (SSI) or Temporary Assistance for

Needy Families (TANF).

10. "Title XXI" means the section of the Social Security Act that authorizes the State Children's Health Insurance Program known as KidsCare in Arizona.

A. TARGETED SUPPORT COORDINATION CASE MANAGEMENT ACTIVITIES

1. The Support Coordinator assigned to support the Member shall:
   a. Develop the planning document at the time of the initial visit for new Members eligible for TSC and review and update at each subsequent meeting.
   b. Annually explain the Member's rights and responsibilities including the procedures for filing a grievance and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.
   c. Inform the Responsible Person of the medical and behavioral health options available through the Member's AHCCCS Complete Care or ACC health plan and direct the

Responsible Person in coordinating these services.

d. Locate, assess, and coordinate social, educational, and other resources to meet the Member's needs.

e. As requested by the Responsible Person, provide necessary information regarding the Member's functioning level and any changes to assist the medical and behavioral health providers in planning, delivering and monitoring services.

   i. Provide Members, Member's family, or other caregivers, the support necessary to obtain benefits from available services or resources.

   ii. Create goals to strengthen the role of family as primary caregivers.

   iii. Provide assistance to reunite families with children who are in an alternative setting whenever possible.

   iv. Identify community resources to prevent costly, inappropriate, and unwanted out-of-home

placement.

v. If the Member has needs that cannot be met through community and natural supports, complete the Preadmission Screening or "Pre-Pas" and, if appropriate, submit a referral to ALTCS. **Note:** Members over the age of 3 receiving state-funded services must comply with the ALTCS application process.

vi. Provide contact with the Member at the requested type and frequency.

B. LEVEL OF CONTACT

1. The Support Coordinator shall conduct an in-person meeting with the Member and their Responsible Person within 10 business days upon notification of the Member's eligibility for TSC.

2. The Support Coordinator, after the initial meeting, shall schedule two additional in-person reviews at 90-day intervals from the date of the initial meeting with the Member and the Responsible

Person.

3. The Support Coordinator shall offer the Responsible Person the choice of type and frequency of contact at the second 90-day planning meeting.

   a. The type of contact may be in-person, by telephone, or by individualized letter.

   b. The Responsible Person may choose the frequency of contact – e.g., 30 days, 90 days, 180 days, 365 days. The frequency of contact cannot be more than 365 days.

   c. The choice will be given to the foster family and communicated to the legal guardian for a foster child in the custody of the Department of Child Safety or Tribal Social Services.

   d. The Responsible Person may change the type and/or frequency of contact at any time by contacting their Support Coordinator.

4. The Support Coordinator shall follow the minimum requirements of contact and planning meeting reviews established by rule,

policy, or procedure if the member is receiving services funded by the Division (i.e., "state-funded") or the Arizona Early Intervention Program (AzEIP).

5. The Support Coordinator shall allow the Responsible Person to choose more frequent contact if desired.

6. The Division shall require minimum contact in the following circumstances:

    a. Members receiving early intervention (AzEIP) services shall have in-person TSC visits every 90 or 180 days.

    b. Members receiving in-home support services (e.g., Attendant Care, Habilitation – Individually Designed Living Arrangement, Respite, etc.) or residing in a Child/Adult Developmental Home shall have in-person TSC visits at least every 90 days.

    c. Members residing in a licensed residential setting (e.g., group home, Skilled Nursing Facility, etc.) regardless of behavioral health services shall have TSC visits occur every 180 days from the date the placement began.

7. The Support Coordinator shall not be required to hold the initial 10-day and two 90-day meetings if the member loses TSC eligibility but becomes eligible again within 6 months.

8. The Support Coordinator shall treat the Member as newly TSC eligible if more than 6 months have lapsed.

C. DOCUMENTATION

1. The Support Coordinator shall update the Member's case record to include:
   a. The date the Support Coordinator was notified that the member is TSC eligible or the Focus task;
   b. Identification of Member as enrolled in TSC;
   c. A description of the type and frequency of contact chosen by the Responsible Person;
   d. Identification of all TSC contacts made and/or attempted including certified letter (when applicable);
   e. A description of the Member's abilities, supports and needs; and

f. Assistance provided to the Responsible Person

2. The Support Coordinator shall consult with their supervisor if the Responsible Person refuses to participate in the TSC program and based on this discussion, document the decision to move the Member to Inactive status or proceed to case closure as outlined in Division Medical Policy 1650.

D. DIVISION RESPONSIBILITIES

1. The Division shall ensure staff are qualified and employed in sufficient numbers to meet Support Coordination needs and responsibilities.

2. The Division shall ensure staff receive initial and ongoing training regarding Support Coordination responsibilities for the TSC program.

3. The Division shall identify new members who are eligible for TSC services and assign a Support Coordinator.

4. The Division shall ensure the Responsible Person is informed of the assignment of the Support Coordinator, when the Support Coordinator is changed, and how the Support Coordinator can

be contacted.

5. The Division shall establish and maintain an internal monitoring system of the TSC program and make results available at the time of annual review, to include a summary/analysis and corrective action plan, when applicable.

6. The Division shall follow prescribed timeframe requirements for the completion of the Planning Document.

7. The Division shall establish and maintain an internal monitoring system of the TSC program and make results available at the time of AHCCCS' Operational Review of the Division to include a summary/analysis and corrective action plan, when applicable.

1650 DIVISION ONLY (DD-ONLY) ELIGIBILITY SUPPORT COORDINATION STANDARDS

REVISION DATE: 12/13/2023
REVIEW DATE:
EFFECTIVE DATE: July 6, 2021

PURPOSE

This policy outlines the responsibilities Support Coordination has for members who are eligible for the Division but do not qualify for Arizona Long Term Care System, "ALTCS", or Targeted Support Coordination.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.
5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.
6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's needs through communication and available supports to promote

quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. DD-ONLY CASE MANAGEMENT ACTIVITIES

1. The Support Coordinator assigned to support the Member shall:

   a. Develop the planning document at the time of the initial visit for new Members and review and update it at each subsequent meeting.

   b. Annually explain the Member's rights and responsibilities including the procedures for filing a grievance and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.

2. The Support Coordinator shall assist in identifying available resources to support the Member including:

a. School Programs

b. Employment (e.g., applying for a job, Vocational Rehabilitation)

c. Community/Recreational Center Programs

d. Day Care Services

e. Diagnostic and educational centers

f. Respite available through community or other grant programs

g. Therapy Services through a school, Third Party Insurance or other resources

h. AHCCCS insurance depending upon the member's income and resources

i. Other state or federal benefits

3. The Support Coordinator shall complete a Pre-PAS to determine if the member is potentially eligible for long-term care and assist with applying for the Arizona Long Term Care System

when the Member has service needs that cannot be met through community resources and natural supports.

B. LEVEL OF CONTACT

1. The Division shall defer to the Arizona Early Intervention Program Contractor for conducting Planning Meetings for Members under age three who are enrolled in the Arizona Early Intervention Program.
2. The Support Coordinator shall conduct an in-person planning meeting with Members who are age 3 years and older:
    a. Within 30 days of eligibility notification.
    b. Followed by two additional Planning Meetings to be held every 180 days.
    c. The Responsible Person shall determine the frequency and type of contact after the first three Planning Meetings.
    d. The Support Coordinator shall make contact with the Member at least annually based on the type of contact chosen.
3. The Support Coordinator shall update the Planning Document

at all Planning Meetings.

C. INITIAL PLANNING MEETING

1. The Support Coordinator shall
    a. Contact the Responsible Person within 10 days of Member eligibility notification to schedule the Planning Meeting;
    b. Conduct the Planning Meeting with the Member present within 30 days of eligibility notification; and
    c. Complete the Planning Document

D. INACTIVE STATUS

1. The Division shall allow a Member who is not actively being served by the Division to choose to be designated with inactive status.
2. The Division shall exclude the following members from inactive status:
    a. Arizona Long Term Care System (ALTCS) eligible;
    b. Targeted Support Coordination (TSC) eligible;
    c. Enrolled in Arizona Early Intervention Program (AzEIP);
    d. In the foster care system;

e. Currently authorized for services paid for by the Division; and/or,

f. Served by the Division as their Representative Payee.

3. When the Responsible Person selects to be inactive the Support Coordinator shall:

a. Update the Case Status Screen in Focus from Active to Inactive in consultation with the Supervisor; and

b. Manually add and edit an Annual Phone Contact Task in Focus; and

c. Contact the Responsible Person annually by phone and document this contact or all attempts to contact in the progress notes.

d. Annually conduct a file review of the member's case file of the following:

i. Current Planning Document

ii. Request a Re-determination of eligibility if one has not been done age at age 6 or 18;

iii. Obtain school records, if school age;

iv. Verify the status of referrals to community resources and document efforts to verify in Progress Notes, and if needed, complete any follow-up;

v. Review and update the Member's screens in Focus.

vi. Document in the electronic Progress Notes that the file review was completed, including any further follow-up that is needed, and update the PCSP Date History in Focus with the date the file was reviewed.

4. The Support Coordinator shall update the Case Status Screen in Focus according to the request when the Responsible Person requests services or elects to be active.

5. The Support Coordinator shall assist the Responsible Person if they request community resources.

   a. One time assistance shall be documented in the progress notes;

   b. On-going assistance shall be documented in the progress notes and the Case Status Screen in Focus shall be updated from Inactive to Active.

200 REQUIREMENTS FOR DIVISION ELIGIBILITY OVERVIEW

REVISION DATE: 5/29/2019, 4/17/2015
EFFECTIVE DATE: January 15, 1996

A person is eligible to receive services, within available appropriations, from the Division if that person voluntarily applies, is a resident of Arizona, is a citizen or legal resident of the United States, gives informed consent, cooperates with the Arizona Long Term Care System (ALTCS) eligibility process, and meets established diagnostic and functional criteria. It is the responsibility of the applicant, with guidance from the Division as needed, to provide the Division with a full complete record of the applicant's developmental, educational, familial, health, histories, including all relevant and accessible reports of psychological evaluations completed for the applicant.

The specific criteria for each of these eligibility requirements are described in this chapter.

200-A RESIDENCY

REVISION DATE: 5/29/2019, 4/17/2015

EFFECTIVE DATE: January 15, 1996

EREFERENCES: A.R.S. §§ 8-548, 36-559

A person is eligible to apply for services from the Division if such person is a bona fide resident of the State of Arizona.

Resident means a person who physically resides within the State of Arizona with the intent to remain. The person who would receive the services must be the resident except in the case of minors whose residency is deemed to be the same as that of the custodial parent(s). The residency requirement is not applicable to foster children who are placed pursuant to

A.R.S. § 8-548 and federal law regarding the Interstate Compact on the Placement of Children (ICPC).

The person signing the DDD application is affirming that the individual who would receive the services is a resident of the State of Arizona.

200-B CITIZENSHIP OR LEGAL RESIDENCY

EFFECTIVE DATE: 5/29/2019

EREFERENCES: A.R.S. §§ 46-140-01 (formerly known as Arizona Proposition 200)

A person is eligible to apply for services from the Division if the person is a citizen of the United States, legal resident of the United States or otherwise lawfully present in the United States.

All applicants must provide documentation showing that the person who would receive the services has lawful legal status. Legal status information is only required for the person needing services.

200-C SOCIAL SECURITY NUMBERS

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: The Federal Privacy Act, 5 U.S. Code § 552a (1974)

The Federal Privacy Act, 5 U.S. Code § 552a (1974) provides that a state agency cannot require, as a condition for receiving any right, benefit or privilege provided by law, the disclosure of a member's Social Security Number unless:

A. The records system predates 1975 and used Social Security Numbers as identifiers; or,

B. It has received special permission from Congress to require a Social Security Number.

The Division of Developmental Disabilities does not meet either criteria and, therefore, cannot require an individual or family to disclose their Social Security Number.

An individual or family may voluntarily disclose their Social Security Number.

200-D CONSENT FOR APPLICATION FOR SERVICES

REVISION DATE: 10/1/2019, 5/29/2019, 4/17/2015

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 36-560(A); 36-560(D); 36-560(E); A.A.C. R-6-6-402

Application shall be made on the forms specified in this chapter. Such form(s) must be signed by the responsible person. No admission to services may be made for any person without the consent of the responsible person.

For persons age 18 or over, the responsible person is the individual, unless that person has been adjudicated legally incapacitated and a guardian established by court order, in which case the legal guardian is the responsible person.

For persons under the age of 18, the legally responsible person is the parent, or a court appointed guardian. If the child is a dependent ward of the court, the Department of Child Safety caseworker may sign the application. For children between the ages of 14 to 18 who live in residential settings supported by the Division, the child must also sign the application unless the Eligibility Specialist determines that the child does not appear to be capable of giving voluntary informed consent.

An adult capable of giving consent may apply for services from the Division. If an adult applies for admission and reasonably appears to the Department to be impaired by a developmental disability to the extent that they lack sufficient understanding or capacity to make or communicate responsible decisions regarding their person, the Division will require that prior to receiving programs or services, the person have a guardian appointed or shall have had a judicial determination made that it is not necessary to appoint a guardian for such person.

An adult applying for services will be presumed capable of giving consent unless there is a court order declaring the person is legally incapacitated or the person's records indicate a diagnosis of profound or severe cognitive/intellectual disability. Family members applying on behalf of an individual described as having profound or severe cognitive/intellectual disability will be advised to review legal options which may include guardianship; conservatorship; durable general power of attorney; representative payee; and/or Advanced directives for Health and Mental Health Care, Prehospital Medical Care Directive, and Living Will.

200-E RESPONSIBLE PERSON AND APPLICATION

REVISION DATE: 5/29/2019, 4/17/2015

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 36-551(36)

The responsible person as defined in A.R.S. § 36-551(36) must:

A. Sign application provided by the Division;

B. Participate in face-to-face interview with a designated Department employee if requested by the Eligibility Specialist or applicant;

C. Show evidence that the person who would receive the services is a resident of Arizona;

D. Provide proof of the person who would receive the services age and health insurance; and,

E. Supply documentation of the developmental disability in conjunction with the application.

200-F COOPERATION WITH ARIZONA LONG TERM CARE ELIGIBILITY PROCESS

REVISION DATE: 5/29/2019

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. §§ 36-559(B) (C), 36-560(C)

The Division must inform the individual/responsible person of the eligibility requirement regarding application for the ALTCS, as described in this policy. The individual/responsible person shall cooperate with the ALTCS application process prior to receiving services from the Division. Applicants voluntarily refusing to cooperate in the ALTCS eligibility process, including re-determination, are not eligible for Division services. Voluntary refusal to cooperate will not be construed to mean that the applicant is unable to obtain documentation required for eligibility determination.

In situations of immediate and compelling need, short-term services may be provided to members with a developmental disability who are in the process of ALTCS eligibility determination.

The responsible person must sign the DD-525 Application for Eligibility Determination form explaining loss of benefits due to voluntary refusal to cooperate in the ALTCS eligibility determination process. See this Policy Manual regarding determination of potential eligibility for ALTCS.

200-G DIAGNOSTIC AND FUNCTIONAL CRITERIA FOR INDIVIDUALS AGE SIX AND ABOVE

REVISION DATE: 6/26/2019, 11/18/2016, 4/1/2016, 3/5/2016
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. §§ 36-551 and 36-559; A.A.C. R6-6-303

Individuals age six and above are eligible to receive services from the Division, subject to appropriation, if they have a developmental disability and meet all other criteria for eligibility with the Division, pursuant to A.R.S. §§ 36-551 and 36-559, and Title 6, Chapter 6, Article 3 of the Arizona Administrative Code (A.A.C.).

"Developmental disability" as defined in A.R.S. § 36-551 means either a strongly demonstrated potential that a child under six years of age has a developmental disability or will develop a developmental disability, as determined by a test performed pursuant to A.R.S. § 36-694 or by other appropriate tests, or a severe, chronic disability that:

A. Is attributable to cognitive disability, cerebral palsy, epilepsy, or autism.

B. Is manifested before the age of eighteen.

C. Is likely to continue indefinitely.

D. Results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self-care.

2. Receptive and expressive language.

3. Learning.

4. Mobility.

5. Self-direction.

6. Capacity for independent living.

7. Economic self-sufficiency.

E. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.

"Manifest before age eighteen," as defined in A.R.S. § 36-551, means that the disability must be apparent and have a substantially limiting effect on an individual's functioning before age eighteen. At least one of the four qualifying conditions identified in A.R.S.§ 36-551, (cognitive/intellectual disability, autism, cerebral palsy, or epilepsy), must exist prior to the individual's eighteenth birthday.

"Likely to continue indefinitely," as defined in A.R.S. § 36-551, means that the developmental disability has a reasonable likelihood of continuing for a protracted period of time or for life. According to professional practice, "likely to continue" in relation to Traumatic Brain Injury (TBI) occurring prior to age 18, means that the condition must

continue to exist at least two years after the diagnosis was made.

"Substantial functional limitation," as defined in A.R.S. § 36-551, means a limitation so severe that extraordinary assistance from other people, programs, services, or mechanical devices is required to assist the individual in performing appropriate major life activities.

Cognitive / Intellectual Disability

"Cognitive disability," as defined in A.R.S. § 36-551, means a condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before age of eighteen, and that is sometimes referred to as "intellectual disability."

"Subaverage general intellectual functioning," as defined in A.R.S. § 36-551, means measured intelligence on standardized psychometric instruments of two or more standard deviations below the mean for the tests used.

"Adaptive behavior," as defined in A.R.S. § 36-551, means the effectiveness or degree to which the individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group.

A. Cognitive/Intellectual Disability is a neurodevelopmental disorder with onset during the developmental period. The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions. Acceptable documentation of cognitive/intellectual disability is a psychological or psychoeducational report prepared by a licensed psychologist, a certified school psychologist, or a psychometrist working under the supervision of a licensed psychologist or certified school psychologist. The psychologist must administer or supervise the administration of a reasonable battery of tests, scales, or other measuring instruments (instruments). The administered instruments must be valid and appropriate for the individual being tested, which includes considerations of physical impairments as well as being culturally and linguistically appropriate and psychometrically sound. The instruments used should be editions current for the date of testing. Critical components for tests administered include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy.

B. Documentation must show the following were considered during the psychological evaluation:

1. Other mental disorders identified in current guidelines established by the American Psychiatric Association, including schizophrenia, bipolar disorder, attention deficit hyperactivity disorder, and substance abuse;

2. Significant disorders related to language or language differences;

3. Physical factors, including sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain;

4. Testing performed during an acute inpatient hospitalization;

5. Educational or environmental deprivation; and

6. Psychosocial factors.

"Measured intelligence" means individually administered tests of intelligence measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with cognitive/intellectual disability have scores of two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65−75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance. Examples of tests of intelligence typically accepted include, but are not limited to, the Wechsler Intelligence Scales (Wechsler Preschool and Primary Test of Intelligence, Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence Scale), the Stanford-Binet, and the Kaufman Assessment Battery for Children.

C. Examples of testing instruments from which IQ equivalent scores are sometimes obtained, but cannot be used as the sole source for determining cognitive/intellectual disability include, the Peabody Picture Vocabulary Test, Raven's Coloured or Standard Progressive Matrices, Matrices Analogies Test, Wechsler Abbreviated Scale of Intelligence, or assessments in which only portions of a Wechsler test are administered.

D. The presence of cognitive/intellectual disability must be properly documented in the diagnostic section of the psychological or medical report. To determine eligibility, a diagnosis of cognitive/intellectual disability must also be supported by medical or psychological documentation to support the diagnosis and related impairments in adaptive functioning. A report that contains only an IQ test score must not be used as the sole source of justification that there is a presence of cognitive/intellectual disability.

E. The purpose of psychoeducational evaluations is not diagnostic, but instead to identify educational accommodations and placement. If the available documentation is a psychoeducational evaluation, the educational classifications of a child with Mild Mental Retardation (MIMR) and a child with Moderate Mental Retardation (MMR) are not equivalent to a diagnosis of cognitive/intellectual disability for the purpose of eligibility with the Division. Psychoeducational evaluations from school psychologists that do not include a formal diagnostic statement regarding cognitive/intellectual disability may eventually contribute to the eligibility determination if the data in the educational record is consistent with the diagnosis of cognitive/intellectual disability per A.R.S. § 36-551.

F. A complete psychological or psychoeducational evaluation report includes a medical, social, and/or educational history, a summary of previous testing results, results of the evaluator's interview with and/or observations of the individual and results of the individual tests of the battery administered. Useful scales designed to quantify adaptive behavior include, the expanded form of the Vineland Adaptive Behavior Scales and the American Association on Intellectual and Developmental Disabilities Adaptive Behavior Scales. Test scores alone are not a sufficient measure of adaptive behavior since most instruments are informant-based, rather than dependent upon direct observation of the individual, therefore, the most desirable assessment of adaptive behavior includes both standardized informant-based measures and direct observation of the individual in the individual's natural settings of home, school, or employment.

G. The best indicators of an impairment of adaptive behavior are the results of an

appropriately administered, scored, and interpreted comprehensive measure (e.g., communication, academic/vocational, level of leisure activities).

H. Conditions such as acute or chronic mental illness, behavioral disturbances, substance abuse, adjustment disorders, and sensory impairments have been shown in clinical research to reduce the level of adaptive functioning. When these factors or other potentially influencing factors are present for an individual, the impact of the factor or factors on adaptive functioning should be fully discussed in the psychological report.

Cerebral Palsy

"Cerebral palsy," as defined in A.R.S. § 36-551, means a permanently disabling condition resulting from damage to the developing brain that may occur before, after, or during birth and that results in loss or impairment of control over voluntary muscles.

A. Acceptable documentation must be by a licensed physician indicating the presence of cerebral palsy.

B. If the medical records contain a diagnosis of spastic quadraparesis, hypotonia, athetosis, and similar conditions but do not refer specifically to cerebral palsy, there must be documentation to confirm the condition results from injury to the developing brain.

C. Unacceptable documentation of cerebral palsy includes muscular dystrophies, arthrogryposis, and muscular or skeletal conditions. Individuals who have acquired impairment in control of voluntary muscles as a result of illnesses or traumatic brain injury occurring after age six are not eligible in the absence of other qualifying conditions.

Epilepsy

"Epilepsy," as defined in A.R.S. § 36-551, means a neurological condition characterized by abnormal electrical-chemical discharge in the brain. This discharge is manifested in various forms of physical activity called seizures.

A. Acceptable documentation must be by a licensed physician (e.g., neurologist, orthopedist, or specialist in rehabilitation medicine) with expertise in diagnosing neurological disorders.

B. When records of an evaluation by a neurologist are unavailable but there are records available that include a diagnosis and clinical documentation of epilepsy or seizure disorder by a licensed physician who does not specialize in neurology, the Division Medical Director will review the available medical records to confirm a diagnosis.

C. Individuals with a history of febrile seizures or febrile convulsions in the absence of other qualifying diagnoses are not eligible for services from the Division.

Autism

"Autism" is defined in A.R.S. § 36-551 as a condition characterized by severe disorders in communication and behavior resulting in limited ability to communicate, understand, learn, and participate in social relationships.

A. Autism Spectrum Disorder is a neurodevelopmental disorder with onset during the developmental period.

B. A comprehensive evaluation shows the presence of diagnostic criteria and the appropriate number of symptoms of Autism Spectrum Disorder based on the current guidelines in the American Psychiatric Association's Diagnostic and Statistical Manual.

C. Acceptable documentation of autism must be from one of the following

1. Psychiatrist,

2. Licensed psychologist,

3. Neurologist,

4. Developmental pediatrician who has expertise in diagnosing autism, or

5. Pediatrician who has completed specialized training approved by the Division in the diagnosis of Autism Spectrum Disorder.

D. A comprehensive evaluation of autism identifies a diagnosis of Autistic Disorder (American Psychiatric Association's Diagnostic & Statistical Manual [DSM] IV Code 299.00/International Classification of Diseases-9 [ICD-9] Code 299.00 or Autism Spectrum Disorder [DSM 5 Code 299.00/ICD-10 Code F84.0]). In older records, autism may also be called Kanner's Syndrome and/or early infantile autism.

E. Documentation must show the following were considered during the evaluation process:

1. Other neurodevelopmental, mental, medical and physical conditions

2. Significant disorders related to language or language differences

3. Physical factors (e.g., sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain)

4. Educational and/or environmental deprivation

5. Situational factors at the time of evaluation or psychological testing

6. If psychological testing is performed, the test must be developmentally appropriate at the time of administration.

F. Medical and/or psychological records that refer to "autistic tendencies," "autistic behavior," or "autistic-like disorder" are insufficient to establish eligibility. A diagnosis of DSM-5 Social (Pragmatic) Communication Disorder does not qualify for services.

G. The diagnostic features and symptomology of Autistic Disorder or Autism Spectrum Disorder must have been evident during the developmental stages. The presence of symptoms in the developmental period can be documented in the present with a thorough developmental interview.

H. The purpose of psychoeducational evaluations is not diagnostic, but instead to identify educational accommodations and placement. When the available documentation is a psychoeducational evaluation, the educational classifications of a child with autism or Autism Spectrum Disorder are not equivalent to a diagnosis of autism for the purpose of eligibility with the Division.

Substantial Functional Limitations

In addition to a diagnosis of cognitive/intellectual disability, cerebral palsy, epilepsy, or autism before age 18, documentation must verify substantial functional limitations attributable to one of the qualifying diagnoses in at least three of the following major life activities:

A. Self-care

Self-care means the performance of personal activities that sustain the health and hygiene of the individual appropriate to the individual's age and culture. This includes bathing, toileting, tooth brushing, dressing, and grooming.

A functional limitation regarding self-care is described in A.A.C. R6-6-303 as when an individual requires significant assistance with eating, hygiene, grooming or health care skills, or when the time required for an individual to complete these tasks is so excessive as to impede the ability to retain employment or to conduct other activities of daily living.

Acceptable documentation of substantial functional limitations for self-care may include recent:

1. Medical or behavioral records;
2. Individualized Education Program (IEP) that addresses limitations of self-care goals and objectives;
3. Relevant comments in a psychological or psychoeducational evaluation;
4. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool;
5. Relevant scores on the Vineland Adaptive Behavior Scales; or
6. Other structured standardized tests of adaptive functioning.

B. Receptive and Expressive Language

Receptive and expressive language means the process of understanding and participating in conversations in the individual's primary language, and expressing needs and ideas that can be understood by another individual who may not know the individual.

A functional limitation regarding receptive and expressive language, as described in A.A.C. R6-6-303, occurs when an individual is unable to communicate with others, or is unable to communicate effectively without the aid of a mechanical device, a third person, or a person with special skills.

Acceptable documentation of substantial functional limitations for receptive and expressive language may include recent:

1. Psychological, psychoeducational, or speech evaluation records;

2. Individualized Education Program (IEP) references of severe communication deficits;

3. Use of sign language, a communication board, or an electronic communication device; or

4. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool.

C. Learning

Learning means the ability to acquire, retain, and apply information and skills.

A functional limitation regarding learning, as described in A.A.C. R6-6-303, occurs when an individual's cognitive factors, or other factors related to the acquisition and processing of new information (such as attention factors, acquisition strategies, storage and retrieval), are impaired to the extent that the individual is unable to participate in age appropriate learning activities without utilization of additional resources.

Acceptable documentation of limitations for learning includes verification of placement in a special education program .

D. Mobility

Mobility means the skill necessary to move safely and efficiently from one location to another within the individual's home, neighborhood, and community.

A functional limitation regarding mobility, as described in A.A.C. R6-6-303, occurs when an individual's fine or gross motor skills are impaired to the extent that the assistance of another individual or mechanical device is required for movement from place to place or when the effort required to move from place to place is so excessive as to impede ability to retain employment and conduct other activities of daily living.

Acceptable documentation of limitations for mobility may include:

1. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool; or

2. Medical or educational records indicating the need to regularly use a wheelchair, walker, crutches, or other assistive devices, or to be physically supported by another person when ambulating.

E. Self-direction

Self-direction means the ability to manage one's life, including:

1. Setting goals,

2. Making and implementing plans to achieve those goals,

3. Making decisions and understanding the consequences of those decisions,

4. Managing personal finances,

5. Recognizing the need for medical assistance,

6. Behaving in a way that does not cause injury to self or others, and

7. Recognizing and avoiding safety hazards.

A functional limitation regarding self-direction, as described in A.A.C. R6-6-303, occurs when an individual requires assistance in managing personal finances, protecting self-interest, or making independent decisions that may affect well-being. For children under the age of 18, the Division must compare the child's abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for Disease Control and Prevention and American Academy of Pediatrics.

Acceptable documentation of limitations for self-direction may include:

1. Court records appointing a legal guardian or conservator,

2. Relevant comments in medical or behavioral records,

3. Relevant comments in psychoeducational or psychological evaluation,

4. Relevant objectives in the individualized Education Program (IEP), or

5. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool.

F. Capacity for Independent Living

Capacity for independent living means the performance of necessary daily activities in one's own residence and community, including:

1. Completing household chores;

2. Preparing simple meals;

3. Operating household equipment such as washing machines, vacuums, and microwaves;

4. Using public transportation; and

5. Shopping for food, clothing, and other essentials.

A functional limitation regarding the capacity for independent living, as described in A.A.C. R6-6-303, occurs when an individual needs supervision or assistance for the individual's safety or well-being on at least a daily basis in the performance of health maintenance and housekeeping. For children under the age of 18, the Division must compare the child's abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for

Disease Control and Prevention and American Academy of Pediatrics, including:

1. Age of the child,
2. Culture,
3. Language,
4. Length of time to complete task,
5. Level and type of supervision or assistance needed,
6. Quality of task performance,
7. Effort expended to complete the task performance,
8. Consistency and frequency of task performance, and
9. Impact of other health conditions.

Documentation of limitations for the capacity for independent living may include:

1. Relevant comments in a psychoeducational or psychological evaluation,
2. Related objectives on the Individualized Education Program (IEP), or
3. Relevant comments in medical records.

G. Economic Self-Sufficiency

Economy self-sufficiency means the ability to independently locate, perform, and maintain a job that provides income above the federal poverty level.

A functional limitation regarding economic self-sufficiency as described in A.A.C. R6-6-303 occurs when an individual is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that earned annual income, after extraordinary expenses occasioned by the disability, is below the poverty level. For children under the age of 18, the Division must compare the child's abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for Disease Control and Prevention and American Academy of Pediatrics.

Acceptable documentation of limitations for economic self-sufficiency may include:

1. The receipt of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits, or
2. Eligibility for Vocational Rehabilitation Services.

RECORDS REQUIRED FOR INDIVIDUALS "AT RISK"

Eligibility for services from the Division prior to the age of six is due to being determined as "at-risk" of developmental disability does not guarantee a member will continue to be eligible for services from the Division after turning six years old. The criteria for an individual age six years and above must be met. If the Division has documentation of an

eligible diagnosis and required functional limitations that meet all requirements for eligibility, no new documentation is required. If an eligible diagnosis is not clear in the individual's records, additional records will be required to establish eligibility.

200-H CRITERIA FOR CHILDREN BIRTH TO AGE 6

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-301(F)

A child under the age of 6 years may be eligible for services if there is a strongly demonstrated potential that the child is or will have a developmental disability as determined by the appropriate tests. Developmental Disability is defined in this Policy Manual.

In the absence of other qualifying circumstances, children with the following conditions are not eligible for services:

A. Congenital Heart Defect;

B. Muscular Dystrophy;

C. Orthopedic Disorders;

D. Speech Delay Involving Only Intelligibility;

E. Significant Auditory Impairment; or,

F. Significant Visual Impairment.

In accordance with A.A.C. R6-6-301(F), to be eligible for Division services, a child birth to age 6 shall meet at least one of the following criteria:

A. Have a diagnosis of cerebral palsy, epilepsy, autism, or cognitive/intellectual disability;

B. There is a strong demonstrated potential that a child is or will have a developmental disability (i.e. the parent or primary caregiver has a developmental disability and there is likelihood that without early intervention services the child will have a developmental disability.) Children diagnosed with the following conditions may be at risk of a developmental disability:

    1. Spina bifida with Arnold Chiari malformation;

    2. Periventricular leukomalacia;

    3. Chromosomal abnormalities with high risk for cognitive/intellectual disability such as Downs Syndrome;

    4. Autism Spectrum Disorders;

    5. Post natal traumatic brain injury such as “shaken baby syndrome” or near drowning;

6. Hydrocephaly;

7. Microcephaly;

8. Alcohol or drug related birth defects such as Fetal Alcohol Syndrome; and,

9. Birth weight under 1000 grams with evidence of neurological impairment.

C. Have demonstrated a significant developmental delay based on performance on a norm-referenced or criterion-referenced developmental assessment that is culturally appropriate. This developmental assessment must also be a professionally accepted tool which indicates that the child has 50% delay in one of the following five developmental domains, or that the child has 25% delay in two or more of the following five domains:

1. Physical (fine and/gross motor, vision or hearing);

2. Cognitive;

3. Communication;

4. Social Emotional;

5. Self Help.

Developmental delay will be determined by a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools and his/her informed clinical opinion.

Example: Child is 24 months old at testing

Test Results:

1. Cognitive - 18 months

2. Gross Motor - 23 months

3. Fine Motor - 23 months

4. Social/Emotional - 22 months

5. Adaptive/Self Help - 22 months

6. Communication - 18 months

In this example, the child has 25% delay in both cognitive and communication skills and is at risk of a developmental disability.

Examples of acceptable developmental evaluation tools include, but are not limited to, the Bayley Scales of Infant Development, the Battle, and the Hawaii Early Learning Profile (H.E.L.P.).

Acceptable documentation of the potential that a child birth to age 6 is or will have a developmental disability includes, medical records indicating an at-risk condition, results of an acceptable developmental assessment, or a signed statement from a licensed physician, licensed psychologist, or other professional trained in early childhood development specifying his/her clinical opinion as to the child's disability or delay.

200-I ADULT APPLICANTS WITH LIMITED DOCUMENTATION

EFFECTIVE DATE: 5/29/2019

REFERENCES: A.R.S. § 36-551

When documents are not available indicating the person, who would receive the services had a qualifying diagnosis prior to age 18, the following documentation can be provided in lieu of the documentation requirements described in the Diagnostic and Functional Criteria (Section 200-G).

A. Establishing a Qualifying Diagnosis

Documentation of a diagnosis or condition that is likely to result in a qualifying diagnosis may be accepted.

1. For Cognitive/Intellectual Disability, documentation of the following is accepted:

   a. Agenesis of the Corpus Callosum

   b. Cri Du Chat Syndrome

   c. Chromosome 8p deletion

   d. Congenital Cytomegalovirus (CMV)

   e. Dandy Walker Syndrome

   f. DNA Methyltransferase 3 Alpha (DNMT3A)

   g. Fetal Alcohol Syndrome / Fetal Alcohol Spectrum Disorders

   h. Kabuki Syndrome

   i. Lowe Syndrome (Oculo-Cerebro-Renal Disease)

   j. Mowat-Wilson Syndrome

   k. Periventricular Leukomalacia

   l. Post-natal Traumatic Brain Injury (e.g.: near drowning, stroke)

   m. Smith Lemli Opitz

   n. Trisomy 8 (Warkany syndrome)

   o. Trisomy 13 or 18 (Edwards Syndrome)

   p. Trisomy 21 (Down Syndrome)

   q. Williams Syndrome

2. For Epilepsy, documentation of the following is accepted:

   a. Agenesis of the Corpus Callosum

   b. Cri Du Chat Syndrome

   c. Congenital Cytomegalovirus (CMV)

   d. Dandy Walker Syndrome

   e. Kabuki Syndrome

   f. Lowe Syndrome (Oculo-Cerebro-Renal Disease)

   g. Maple Syrup Urine

   h. Phenylketonuria (PKU)

3. Cerebral Palsy, documentation of the following is accepted:

   a. Mowat-Wilson Syndrome

   b. Agenesis of the Corpus Callosum

4. Autism Spectrum Disorder, documentation of the following is accepted:

   a. Smith Lemli Opitz

B. Establishing Substantial Functional Limitations

An applicant may have difficulty showing substantial functional limitations if they are not enrolled in an educational program, work program or day program. In this case, an Inventory for Client and Agency Planning (ICAP) can be completed to show substantial functional limitations.

201 APPLICANTS WITH DOWN SYNDROME

EFFECTIVE DATE: October 26,2022

REFERENCES: A.R.S. § 36-551; Division Eligibility Policies 200 G, H, I, 400, and 600.

PURPOSE

The purpose of this policy is to amend the Division of Developmental Disabilities (DDD or Division) qualifying diagnosis information to include Down Syndrome.

DEFINITIONS

"Down Syndrome" means a genetic disorder caused when abnormal cell division results in extra genetic material from chromosome 21, affecting a person's cognitive and physical abilities and causing developmental issues.

POLICY

A. QUALIFYING DIAGNOSIS

1. The Division shall accept Down Syndrome, in addition to Autism, Cerebral Palsy, Epilepsy, and Cognitive/Intellectual Disability, as a qualifying diagnosis for the purpose of eligibility determination.

2. In all DDD policies relating to eligibility for Division services, the Division shall recognize Down Syndrome as the fifth qualifying diagnosis.

B. DOCUMENTATION

1. The Division shall require an evaluation report, which shall include a description of how the practitioner came to the decision based on prenatal or postnatal genetic testing.
2. The Division shall accept evaluations by licensed primary care physicians, developmental pediatricians, neonatologists, and clinical geneticists.

400 ELIGIBILITY DETERMINATION PROCESS

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-303.

Determinations or re-determinations of eligibility are subject to review at any time by the Division Assistant Director or designee.

Following the intake interview, the intake worker will immediately mail the signed *Authorization for Release of Information* form to the applicable agencies and professionals in order to obtain needed medical, psychological, school, and social service records.

A. The Eligibility Clock

Eligibility for all applicants shall be determined within 60 days of the application date. If records required to complete the eligibility determination have not been received within 30 days of the application date, the applicant/responsible person shall be notified by letter that records shall be received within 30 days or the application may be denied, unless the child is eligible for the Arizona Long Term Care System (ALTCS) or is age birth to three years.

There are two circumstances in which the eligibility clock is shorter, please refer to "B" and "C" below.

B. The Eligibility Clock for Arizona Early Intervention Program (AzEIP) (children, birth to three years).

Eligibility for children birth through three years of age who are referred by or for AzEIP must be determined within 30 days and an initial Individualized Family Services Plan (IFSP) meeting held within 45 days of referral to AzEIP.

C. The Eligibility Clock for Initial Referrals Directly from Arizona Health Care Cost Containment System (AHCCCS)

Eligibility for initial referrals must be determined within 30 days of receipt of the initial referral when the referral source is ALTCS. If records required to complete the eligibility determination have not been received within 15 days of the referral date, the applicant/responsible person will be notified by letter that the records must be received within 15 days of the letter or the application will be denied.

The Division works with AzEIP who is responsible for the eligibility process.

Upon receipt of records, the intake worker will forward the entire intake file to the staff designated to make the eligibility determinations or re-determinations for that district/area. Designated staff will summarize the reasons for determination of eligibility or ineligibility with particular attention to describing functional limitations, when applicable.

Prior to determination or re-determination, the following types of situations shall be referred to the office of the Division Assistant Director/designee for specialized review and recommendation:

A. Traumatic brain injury occurring prior to age 18, in the absence of an appropriate rehabilitation history;

B. Pervasive developmental disorder, not otherwise specified or pervasive developmental disorder;

C. Asperger's Disorder, if there is question as to whether the person has a developmental disability as defined by Arizona statute;

D. Persons with an IQ in the cognitive/intellectual disability range who have an Axis I mental health diagnosis, if the diagnosis of a developmental disability as defined by Arizona statute is questionable;

E. Persons with a full scale IQ in the cognitive/intellectual disability range, if there is a difference of one or more standard deviations between the performance IQ and the verbal IQ and the diagnosis of a developmental disability as defined by Arizona statute is questionable;

F. Cerebral palsy diagnosed after the age of 6;

G. Rare degenerative conditions, if the diagnosis of a developmental disability as defined by Arizona statute is questionable; and,

H. Children under the age of 6 who have a significant medical disorder that impedes age appropriate functioning but the likelihood of developing one or the four developmental disabilities is unclear.

For these situations, the Division Assistant Director/designee shall ensure that all available records have been obtained and that the entire intake file is reviewed by the appropriate professional(s). The Division Assistant Director/designee shall maintain records regarding the disposition of each referral and identify trends in cases that are referred, coordinating the incorporation of this information into the Division ongoing eligibility training. The date of eligibility shall be the date the person making the eligibility determination signs and approves the application form.

Upon eligibility determination, the intake worker or assigned district staff will update focus and send notice of the decision to the applicant/responsible person. Written notice of ineligibility and intent to deny an application shall be issued by certified mail return receipt requested and shall include notice of appeal rights.

600 REDETERMINATION OF ELIGIBILITY

REVISION DATE: 08/24/2022, 4/17/2015

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.A.C. R6-6-301, *et. seq.*; A.A.C. R6-6-601; A.A.C. R6-6-604; Arizona Revised Statute ("A.R.S.") § 36-551; A.R.S. § 36-559; A.R.S. § 36-565; A.R.S. § 36-694.

PURPOSE

This policy outlines the Department of Economic Security ("Department" or "DES"), Division of Developmental Disabilities ("Division" or "DDD") requirements for redetermining a Member's continued Eligibility for DDD Services.

DEFINITIONS

1. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

POLICY

A. The Division shall redetermine a member's continued eligibility for DDD services at ages six and 18 based on the criteria in Eligibility Manual Policy 200-G.

B. The Division's Assistant Director or designee may also review a member's eligibility at any time.

C. The Department may determine that it is necessary for a member with a qualifying diagnosis to receive continued services to maintain skills or to prevent regression. In the event the Department makes such a determination, the member shall remain eligible for DDD Services.

D. For redeterminations at age six, the Division shall notify the member's responsible person verbally during a scheduled meeting and/or in writing of the redetermination requirements.

E. For redeterminations at age 18, the Division shall notify the member and responsible person verbally during a scheduled meeting and/or in writing of the redetermination requirements, including the need to submit a completed application prior to the member turning 18 years of age.

F. The Division shall offer and provide assistance to the member and responsible person throughout the redetermination process.

G. When redetermining eligibility at ages six and 18, the Division shall:

1. Ensure all required documentation (including a completed application for members turning 18 years of age) has been received and the documentation supports the determination to deny or approve the member's continued eligibility for DDD services;
2. Ensure the responsible person received assistance.
3. Ensure the Notice of Denial or Termination of Eligibility is accurately completed.

H. At the completion of the redetermination process, the Division shall:

1. Send an approval letter, if it is determined that the Member continues to be Eligible for DDD services, to the Member and the Responsible Person.

2. Send a written Notice of Denial or Termination of DDD Eligibility if the member does not continue to be eligible for DDD services. The notice shall be issued by certified mail with a return receipt

requested. The notice will include all reason(s) for the decision to terminate eligibility and provide information regarding members' appeals rights.

700 DETERMINATION OF ARIZONA LONG TERM CARE SYSTEM ELIGIBILITY

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 36-559(C); AHCCCS Eligibility Manual.

Following determination of eligibility for services from the Division, newly eligible members shall be screened for referral to the Arizona Long Term Care System (ALTCS) unless the referral source was ALTCS. Persons who are identified from the screening as potentially eligible for ALTCS shall not receive state funded Division services, except as outlined in this Policy Manual, until the Arizona Health Care Cost Containment System (AHCCCS) determines the person is eligible or ineligible for ALTCS services.

Persons who meet the criteria for both the Resource Screening and the Functional Screening shall be referred to ALTCS.

Resource Screening for Arizona Long Term Care System

The criteria for the financial screening are cash resources less than $2,000 and at least one of the following:

A. Receipt of Supplemental Security Income (SSI); or,

B. Eligible for Temporary Assistance to Needy Families (TANF), 6th Omnibus Budget Reconciliation Act (SOBRA), or other Medical Assistance (MA) categories; or,

C. Monthly income not to exceed 300% of the maximum Supplemental Security Income (SSI) benefit.

A child's income and resources will be considered in the eligibility determination. The income and resources of parents may be waived if the child would have been eligible to receive an ALTCS covered service within 30 days prior to the date of application for ALTCS.

The specific financial criteria used by ALTCS are extremely complicated. Whenever there is doubt about whether a person might meet ALTCS financial criteria, the member should be referred to ALTCS. Additional information regarding ALTCS eligibility is available in the ALTCS Eligibility Manual.

Functional Screening for Arizona Long Term Care System

The age appropriate Preadmission Screening (PAS) evaluation must be completed for all applicants, unless the referral source was ALTCS.
The Support Coordinator should explain to the members/responsible person that the Division may not be able to provide services, other than Support Coordination, to non-ALTCS eligible members, consequently, the members /responsible person may choose to apply for ALTCS, even though the Division is not making a referral.

Pre-Admission Screening

The PAS is both a tool and a process used by AHCCCS to determine medical/functional eligibility for the ALTCS program.

The PAS tool compiles demographic, functional, and medical information for each ALTCS applicant. The PAS instrument measures the level of functional and medical disability and determines when the member is at risk of institutional placement. The PAS is administered by AHCCCS by a registered nurse and/or a social worker. Generally, responsibility for the completion of the PAS for persons served by the Division is as follows:

A. ALTCS nurse and/or social worker perform the PAS for members who are medically involved, including **all** persons who are dependent upon a ventilator, regardless of placement.

B. Nurses or social workers, as single PAS Assessors, may perform the PAS for members who reside in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), group home, developmental home or any Home and Community Based Services (HCBS) setting, who are not medically fragile or dependent upon a ventilator.

The PAS Assessors have an ALTCS physician consultant available for physician review should there be a question of medical eligibility. ALTCS completes their eligibility process within a 45 day period for most applicants.

AHCCCS re-administers the PAS in rare situations. If the member is determined not ALTCS eligible, AHCCCS sends a file to the Division which is then distributed to the appropriate District for printing.

The Planning Team must use the PAS, along with the ICAP, and other assessment information, to develop the Planning Document and substantiate the need for the services to be provided.

Arizona Long Term Care System Referral Procedures

Members who meet both the financial and functional screening criteria will be referred to ALTCS by completion of the, *AHCCCS Medical Benefits Part I* form. The Support Coordinator shall assist the member/responsible person to complete this form and to take or mail it to the local ALTCS Eligibility Office.

The Support Coordinator will ensure the member/responsible person understands that the ALTCS eligibility process requires two steps:

A. Completion of the *Part II Application* via interview with an ALTCS Eligibility Worker and completion of the *PAS* evaluation, via an interview with an ALTCS nurse and/or social worker.

B. ALTCS may also refer a member who is age 18 or over and not receiving Supplemental Security Income or Social Security Administration benefits to Disability Determination Services to establish disability.

The Support Coordinator may serve as an Authorized Representative for ALTCS only for those members who are not able to complete the application process independently and who do not have a family member or guardian readily available to serve as the Authorized Representative.

Arizona Health Care Cost Containment System Roster

The Support Coordinator must check, review and initiate the task assigned in focus on a daily basis to determine when there are members newly eligible for ALTCS. If so, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) must be reviewed/developed in accordance with the timelines and procedures specified in this Policy Manual.

Appeal of Arizona Long Term Care System Eligibility Decisions

The Support Coordinator may, upon request of the member or the responsible person, assist the member in completing forms and taking other procedural steps to appeal a denial of ALTCS eligibility.

800 ELIGIBILITY FOR THE ARIZONA EARLY INTERVENTION PROGRAM

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

Arizona Early Intervention Program (AzEIP) defines as eligible a child between birth and 36 months of age who is developmentally delayed, or who has an established condition that has a high probability of resulting in a developmental delay.

A developmental delay is met when the child has not reached 50% of the developmental milestones expected at his/her chronological age in one or more of the following domains:

A. Physical (fine and/or gross motor, vision or hearing);

B. Cognitive;

C. Communication;

D. Social Emotional; or

E. Self-Direction.

Developmental delay shall be determined by a person meeting the AzEIP personnel standards, such as a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools. Eligibility shall be based on informed clinical opinion and parental input.

When a child is eligible for more than one AzEIP participating agency (e.g., Arizona State School for the Deaf and Blind, Division of Developmental Disabilities) the Individualized Family Services Planning team makes the decision, based on the needs of the family and child which agency will perform the Support Coordinator function**.**

In order for a child who is AzEIP eligible to receive services through the Division, the child must also meet the Division eligibility criteria outlined in this Policy Manual.

900 ELIGIBILITY CATEGORIES

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

There are three types of eligibility: State funded (Division of Developmental Disabilities (DDD)), Targeted Support Coordination (TSC), and Arizona Long Term Care System (ALTCS). Each type has a different mandatory minimum review cycle. Any member receiving services funded by the Division is required to follow the minimum requirements of service review and contact established by this Policy Manual.

A. Members who are DDD receive Support Coordination and direct services based on assessed need and availability of state funds. Members in this category have the right to choose the type of contact, as applicable. These members are not eligible for TSC or ALTCS.

DDD Members have the right to choose the type of contact for required meetings. The types of contact include:

1. In person;

2. By phone; and,

3. By email/mail.

Members who are in this category can select to be placed in Inactive Status after one year of eligibility. Members who select Inactive Status will be contacted by phone annually. For further information, contact the Support Coordinator.

B. Members who are TSC are eligible for Title XIX acute care services including, Early Periodic Screening Diagnosis and Treatment (EPSDT). Members in this category receive Support Coordination and direct services based on assessed need and availability of state funds. Members who are TSC are not eligible for ALTCS.

Members who are TSC or their guardians have the right to choose the type and frequency of contact, as applicable. The member/responsible person may choose to change the type and frequency at any time.

Members who are in this category have the right to choose:

1. The type of contact:

   a. In person;

   b. By phone; and,

   c. By mail.

2. The frequency of contact:

   a. 90 days;

   b. 180 days; and,

   c. Annually.

C. ALTCS

Members who are ALTCS eligible receive Support Coordination, direct services based on assessed need including medical necessity and cost effectiveness, and acute services including, EPSDT. Members eligible for ALTCS have a choice of a Division contracted health plan. Members in this category receiving services funded by the Division are required to follow the minimum requirements of service review and contact established by this Policy Manual.

1001 INVENTORY FOR CLIENT AND AGENCY PLANNING

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

The Division requires that the Inventory For Client And Agency Planning (ICAP) be completed by the Support Coordinator during intake and at redeterminations for members age 6 and over. The Support Coordinator may not delegate responsibility for completion of this evaluation to a provider or to the family. The ICAP is protected by copyright; photocopies of the response booklet may not be used in the administration of the evaluation.

The ICAP is a standardized assessment tool which provides information regarding the member's medical condition and diagnoses, motor skills, social and communication skills, personal living skills, community living skills, social and leisure activities, and problem behaviors, if any.

The information contained in the ICAP is to be used, in conjunction with the Pre-Admission Screening tool and other assessment information, to develop functional statements of need in the Planning Document and to establish the necessity of the services to be provided.

The ICAP provides scores which can be used to determine the level of supervision a member needs.

The Support Coordinator will ensure that the ICAP score for each member is entered in Focus.

100 DEFINITION AND APPLICABILITY

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. § 36-551; A.A.C. R6-6-901.

Arizona Administrative Code R6-6-901, is titled Managing Inappropriate Behavior. Commonly referred to as Article 9, it governs the Division of Developmental Disabilities' (DDD) administration of a comprehensive statewide system for behavioral interventions, and establishes the structure for developing, approving, implementing and monitoring these plans.

All programs operated, licensed, certified, supervised or financially supported by the Division must comply with these policies and procedures. If a need to reduce inappropriate behaviors is identified, the Planning Team must determine whether a behavior treatment plan is needed. Behavior treatment plans, which include any of the interventions outlined in this Policy Manual, must be approved by the Program Review Committee (PRC) and reviewed by the Human Rights Committee (HRC).

200 PROHIBITIONS

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. §§ 36-551(A), 36-561, 36-561(B), 36-569(A); A.A.C. R6-6-9, R6-6-902, R6-6-903(A).

State statute prohibits abusive treatment or neglect of any individual with a developmental disability.

Abuse

Prohibited abusive treatment, as it relates to managing inappropriate behavior, includes programmatic abuse, which uses an aversive stimulus technique that has not been approved as part of a member's Individual Service Plan (ISP), and which is not contained in the rules and regulations. This includes individual isolation.

Neglect

Neglect of an individual with a disability is prohibited. Neglectful treatment means any intentional failure to carry out a behavior treatment plan developed for an individual by the Planning Team.

Behavioral Intervention Techniques

Identified below are those techniques which are prohibited under the provisions of Article 9:

A. Use of locked time-out rooms.

B. Use of over-correction. This means a group of procedures designed to reduce inappropriate behavior, consisting of:

   1. Requiring an individual to restore the environment to a state vastly improved from that which existed prior to the inappropriate behavior; or,

   2. Requiring an individual to repeatedly practice a behavior.

C. Application of noxious stimuli such as ammonia sprays, or Tabasco sauce to the tongue;

D. Physical restraints, including mechanical restraints, when used as a negative consequence to a behavior; and,

E. Any other technique determined by the Program Review Committee (PRC) to cause pain, severe discomfort, or severe emotional distress to the individual.

F. Techniques addressed in A.R.S. § 36-561(A):

   1. Psychosurgery;

   2. Insulin shock;

3. Electroshock; and,

4. Experimental drugs.

Behavior Modifying Medications

Except as indicated and specified in statute and rule, behavior modifying medications are prohibited if any one of the following criteria are met:

A. They are administered on an as-needed or PRN basis;

B. The Planning Team determines that the dosage interferes with the individual's daily living activities; and,

C. They are used in the absence of a behavior treatment plan.

See additional chapters in this Policy Manual for broader information regarding Behavior Modifying Medications.

Behavior Treatment Plan Implementation

No one shall implement a behavior treatment plan that:

A. Is not included as part of the ISP; and,

B. Contains aversive behavior intervention techniques which do not have approval of the (PRC) and review by Human Rights Committee (HRC).

300 VIOLATIONS

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. §§ 36-561, 36-569.

Any person violating the statutory provisions regarding the health and safety of persons with developmental disabilities is guilty of a class 2 misdemeanor.

400 PROGRAM REVIEW COMMITTEE

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.A.C. R6-6-903, R6-6-903(E), R6-6-1701, et seq.; 42 CFR 483.440(f) (3).

The Program Review Committee (PRC) is an assembly designated by the District Program Manager (DPM) that reviews any behavior treatment plan that meets the criteria set forth in this Policy Manual. The Program Review Committee (PRC) approves plans, or makes recommendations for changes as necessary.

Composition

DPM is responsible for designating persons to serve on PRC. At a minimum, the team should include:

A. The DPM or designee as the chairperson;

B. A person directly providing habilitation services;

C. A person determined by the Division as qualified in the use of behavior management techniques, such as a psychologist or psychiatrist;

D. The parent/guardian of a person with a developmental disability, but not the parent of the person whose program is being reviewed;

E. Persons with no ownership/controlling interest in a facility, and no involvement in service provision to persons with developmental disabilities; and,

F. A person with a developmental disability when appropriate.

Responsibilities

PRC must review and respond in writing within 10 working days of the receipt of a behavior treatment plan. The written response must be signed and dated by each member in attendance, forwarded to the Planning Team and a copy sent to the chairperson of the Human Rights Committee (HRC). The written response shall include:

A. A statement of agreement that the interventions approved are the least intrusive, and that they are the least restrictive alternative,

B. Any special considerations/concerns, including specific monitoring instructions, and,

C. Any recommendations for change, with explanations.

PRC shall issue written reports to the DDD Assistant Director, summarizing its activities, findings/recommendations while maintaining the individual's confidentiality. Reports are required:

1. Monthly to the designated Division staff, with a copy to the chairperson of the HRC; and,

2. Annually, by December 31 of each calendar year, to the DDD Assistant Director or designee, with a copy sent to the Developmental Disabilities Advisory Council.

500 INDIVIDUAL SUPPORT PLAN TEAM RESPONSIBILITIES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Responsibilities

The Individual Service Planning Team (Planning Team) must submit to the Program Review Committee (PRC) and Human Rights Committee (HRC) any behavior treatment plan that includes:

A. Techniques that require the use of force;

B. Programs involving the use of response cost. This means a procedure often associated with token economies, designed to decrease inappropriate behaviors, in which reinforcers are taken away as a consequence of inappropriate behavior;

C. Programs that might infringe upon the rights of the individual;

D. The use of behavior modifying medications; and,

E. Protective devices used to prevent an individual from self-injurious behavior.

Upon receipt of the PRC's response, and as part of the plan development process, the Planning Team must either:

A. Implement the approved behavior treatment plan;

B. Accept the PRC recommendation, and incorporate the revised behavior treatment plan into the Individual Service Plan (ISP); or,

C. Reject the PRC recommendation and develop a new behavior treatment plan.

All revised behavior treatment plans must be re-submitted to the PRC and the HRC for review and approval. No implementation shall occur prior to approval.

600 RESTITUTION

REVISION DATE: 7/3/2019, 3/2/2015, 1/31/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-551

Restitution

A. Means the act of paying or compensating for property loss or damage in order to learn alternative behaviors;

B. Does not include voluntary compensation by a parent or guardian; and

C. May not infringe on an individual's rights protected by A.R.S. § 36-551.

Providers are required to have insurance to cover property loss or damage. If a member damages the property of another, the injured party may have a legal remedy in the small claims division of the Justice Courts.

The Division and its contracted providers cannot make restitution a condition for provision of services or supports. A Member's Behaviors cannot prevent that member from receiving services through the Division.

Behaviors that result in property damage or loss should be addressed by the Planning Team.

A. Behavior Plans may include some level of restitution so long as all of the following are met:

1. The member's behavior support plan includes the use of restitution, and has been approved by the planning team, including the member and/or family member/guardian and treating behavioral health professional if applicable;

2. The restitution furthers a goal identified and is individualized in a member's behavior plan;

3. The member has an understanding of the restitution plan and purpose so that the member can accept their responsibility and learn;

4. The behavior plan was implemented as written;

5. The team establishes the restitution amount only after consideration of the member's resources and determination that the member's needs will not be adversely impacted by the payment amount, including that the amount will not adversely impact the member's ability to pay for other items or activities that are necessary to further other plan goals;

6. An invoice and explanation of the cost for each restitution payment is reviewed and approved by the planning team before each restitution payment is made.

700 BEHAVIOR MODIFYING MEDICATIONS, MONITORING BEHAVIOR MODIFYING MEDICATIONS AND TREATMENT PLANS

REVISION DATE: 9/30/2016, 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. § 36-551.01, A.A.C. R6-6-903.A, R6-6-905, R6-6-908, R6-6-909.

Behavior modifying medications are drugs prescribed, administered, and directed specifically toward the reduction and eventual elimination of specific behaviors. Herbal remedies will be included among medications due to their psychoactive and potentially behavior modifying properties.

Behavior modifying medications are only to be prescribed and used:

A. As part of the member's behavior treatment plan included in the Individual Service Plan (ISP); and,

   When in the opinion of a licensed physician, they are deemed to be effective in producing an increase in appropriate behaviors or a decrease in inappropriate behaviors.

B. When it can be justified by the prescribing physician that the harmful effects of the behavior clearly outweigh the potential negative effects of the medication. Two examples of when the risks and benefits of the medications need to be reviewed with members with developmental disabilities, their families, and/or their guardians:

   1. The older antipsychotic medications such as Thorazine (chlorpromazine), Mellaril (thioridazine), Haldol (haloperidol) and Navane (thiothixene) may cause such as tardive dyskinesia, a permanent muscular side effect. Tardive dyskinesia is characterized by slow rhythmic, automatic movements, either generalized or in single muscle groups.

   2. The new antipsychotic medications such as Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quietapine), Abilify (aripiprazole) and Geodon (ziprasidone) are much less likely to cause tardive dyskinesia. However, these medications carry a high risk of significant weight gain. One study found 18 pounds average weight gain in three months. Such significant weight gain can result in the development of a metabolic syndrome, which is defined as three or more of the following:

      a. Increased waist circumference;

      b. Elevated triglycerides;

      c. Reduced HDL (good) cholesterol;

      d. Elevated blood pressure; and,

      e. Elevated fasting glucose.

      These factors lead to a much higher risk of heart disease and diabetes.

The use of behavior modifying medications requires the Division to make available the services of a consulting psychiatrist to review medical records and make recommendations to the prescribing physician, which ensures the prescribed medication is the most appropriate in type/dosage to meet the needs of the individual.

The Division must provide monitoring of all behavior treatment plans that include the use of behavior modifying medications to:

A. Ensure that data collected regarding an member's response to the medication is evaluated at least quarterly at a medication review by the physician and a member of the ISP team, other than the direct care staff responsible for implementing the approved behavior treatment plan; and:

B. Ensure that each member receiving a behavior modifying medication is screened for side effects and tardive dyskinesia as needed, and that the results of such screening are:

   1. Documented in the individual's central case record;

   2. Provided immediately to the physician, individual/responsible person, and ISP team for appropriate action in the event of positive screening results for side effects/tardive dyskinesia; and,

   3. Provided to the Program Review Committee (PRC) and Human Rights Committee (HRC), and the Division's Medical Director within 15 working days for review of the positive screening results.

The member/responsible person must give informed, written consent before behavior modifying medications can be administered. Non-scheduled or as-needed sleep preparations are not allowed, whether prescribed or over-the-counter. Aromatherapy does not require a behavior treatment plan, but must be done with the consent of the member or his/her legal guardian.

See the Division Operations Manual for more detailed information regarding informed consent and the related forms.

Monitoring Behavior Modifying Medications/Treatment Plans

For all behavior treatment plans that include the use of behavior modifying medications, the Division must:

A. Provide second level reviews by a consulting psychiatrist to provide recommendations to the prescribing physician, which ensure that the prescribed medication is the most appropriate in type and dosage to meet the member's needs;

B. Ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly by the physician; and the member of the Individual

Service Planning Team (Planning Team) designated pursuant to A.A.C. R6-6-905, and other members of the Planning Team as needed; and,

C. Ensure that each individual receiving a behavior modifying medication is screened for side effects, and tardive dyskinesia as needed, and that the results of such screening are:

1. Documented in the member's case record;

2. Provided immediately to the physician, member, responsible person, and Planning Team for appropriate action in the event of positive screening results; and,

3. Provided to the Program Review Committee (PRC) and Human Rights Committee (HRC) within 15 working days for review of positive screening results.

In the event of an emergency, a physician's order for a behavior modifying medication may, if appropriate, be requested for a specific one time emergency use. The person administering the medication shall immediately report it to the Support Coordinator, the responsible person, and any applicable Division designee. The responsible person shall immediately be notified of any changes in medication type or dosage.

Paper Reviews

The following guidelines have been designed to provide an option to both the Planning Team and the PRC to meet minimum requirements for annual review of an established behavior treatment plan through a paper review process. This option is limited solely to situations where the individual is on psychotropic medications, and during the annual review by the PRC the presented information and data clearly demonstrate that the member's behavior has been stable for one year.

Applicability

Paper reviews are considered appropriate when the member's behavior treatment plan involves the use of psychotropic medications, including the use of over-the-counter and herbal medications when used to modify behavior, but does not involve the utilization of more restrictive approaches and/or strategies.

Note: The use of psychotropic medications is prohibited if they are administered on an as-needed, or PRN, basis, they are in dosages which interfere with the individual's daily living activities (as determined by the Planning Team), or they are used in the absence of a behavior treatment plan.

If the member's Behavior Treatment Plan includes any of the following techniques and/or strategies, the plan is not eligible for the PRC's paper review process:

A. Techniques that require the use of force;

B. Programs involving the use of response cost;

C. Programs that might infringe upon the rights of the consumers pursuant to applicable federal and state laws, including A.R.S. § 36-551.01; and,

D. Protective devices used to prevent a person from sustaining injury as a result of the person's self-injurious behavior.

For members living in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), federal rules and regulations will take precedence over these guidelines for paper review.

Eligibility

A member's behavior treatment plan may be monitored by the PRC's annual paper review process, if the following criteria are met:

A. The member participated in their program, activities of daily living and chosen leisure/community activities without any significant behavioral disturbances for the previous 12 months. Significant behavioral disturbance is defined as any physical aggression, or pattern of verbal aggression, or other actions that are not typical for the member (such as significant deterioration in personal hygiene or social withdrawal);

B. There were no behavioral incidents requiring the use of emergency measures during the previous 12 months; emergency measures are defined as the use of physical management techniques or psychotropic medications in an emergency to manage a sudden, intense or out-of-control behavior;

C. During the previous 12 months, there were no changes in the member's prescribed psychotropic medications; the exception to this criterion is when the member required an increase in an antidepressant medication and it was in the absence of any behavioral disturbances; and,

D. Through a review of all incident or serious incident reports for the member during the previous 12 months, there were no situations noted where the member's behavior resulted in police involvement, psychiatric hospitalization, or crisis intervention through the behavioral health system.

Initial Consideration of Paper Reviews

For the PRC to consider annual reviews using the paper review process, the Planning Team must provide the following:

A. A copy of the member's current Planning Document;

B. A copy of the member's current behavior treatment plan, with data and information that meets the criteria set forth in the "Eligibility" section above;

C. Documentation that there is on-going medical monitoring, quarterly medication reviews, and laboratory testing as needed; and,

D. Copying of the Reassessment of the Planning Document for the previous 12 months.

Subsequent Annual Paper Reviews

For the PRC to complete subsequent paper reviews of a member's behavior treatment plan, the Planning Team must provide at a minimum:

A. A copy of member's current Planning Document;

B. A copy of the member's current behavior treatment plan, with information or data indicating the individual's continuous stable behavior;

C. Copies of on-going medical monitoring reports, quarterly medication reviews and any required laboratory testing, for the previous 12 months;

D. Copy of the Reassessment of the Planning Document for the previous 12 months; and,

E. Any other information requested by the PRC.

Responsibilities of the Program Review Committee

Upon receipt from the Planning Team of the required information detailed in the sections above, the PRC chairperson will:

A. Schedule a review of the submitted information by the entire membership of the PRC;

B. Request further information, and/or schedule a face-to-face review if during the paper review process it is determined that further information is needed; and,

C. Forward a disposition report to the Planning Team. The disposition report will indicate approval, any recommendations made, and the date of the next scheduled review.

Loss of Eligibility for Paper Review

If any of the following situations occur, the Planning Team must notify the PRC chairperson in writing within 30 days of the occurrence. The Planning Team must also reconvene and, if the behavior treatment plan was amended, forward a copy to the PRC within 90 days. This includes situations where:

A. The member cannot participate in their program, activities of daily living and/or leisure activities of their choice, due to any significant behavioral disturbance;

B. An emergency measure intervention was utilized (physical and/or chemical restraint):

C. Any change or increase in the member's psychotropic medications was made;

D. The only exception to this criterion is when the member requires an increase in an antidepressant medication and it is in the absence of any behavioral disturbances; and,

E. The member's negative behavior results in law enforcement involvement, psychiatric hospitalization, crisis intervention by the behavioral health system, or injury to oneself or others.

Upon receipt of the member's behavior treatment plan from the Planning Team, the PRC will schedule a formal review of the plan. Subsequent PRC reviews of the behavior treatment plan will be conducted face-to-face until the member has been stable on their psychotropic medications for one year.

Exit Criteria

For a member's behavior treatment plan to exit from the PRC's required annual review the following criteria must be met:

A. Discontinuation of psychotropic medications as part of the behavior treatment plan strategy;

B. Psychotropic medication is clearly prescribed for a non-behavior modifying purpose:

1. Rationale for the medication is clearly documented by the prescribing physician as being medical in nature (e.g., migraine, seizures), with no associated behavioral disturbance or issues.

2. The PRC must be satisfied that use of the psychotropic medication will continue to be monitored by the prescribing physician and that there is clearly not a need for a behavior treatment plan to be developed by the Planning Team.

3. Unless otherwise indicated, use of a psychotropic medication prescribed for a non-behavior modifying reason and without the need for a formal behavior treatment plan will only require a one-time review and approval by the PRC.

C. Elimination of the use of other more restrictive approaches/strategies within the behavior treatment plan that require PRC review and approval and/or annual review, per A.A.C. R6-6-903.A:

1. Techniques that require the use of force;

2. Programs involving the use of response cost;

3. Programs which might infringe upon the rights of the individual pursuant to applicable federal and state laws, including A.R.S. § 36-551.01; and,

4. Protective devices used to prevent a member from self-injurious behavior.

D. The member is discharged from services through the Division.

For members living in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), federal rules and regulations will take precedence over the exit criteria outlined above.

900 EMERGENCY MEASURES AND PHYSICAL MANAGEMENT TECHNIQUES

REVISION DATE: 9/30/2016, 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.A.C. R6-6-906, R6-6-909.

Emergency Measures

When an emergency measure, including the use of behavior modifying medications is employed to manage a sudden, intense, and out-of-control behavior, the person employing the measure must:

A. Report the circumstances immediately to the person designated by the Division, the responsible person and the Support Coordinator;

B. Provide a written report of the circumstances of the emergency measure to the responsible person, the Support Coordinator, and the Program Review Committee (PRC) and Human Rights Committee (HRC) chairpersons within one day; and,

C. Request that the Support Coordinator reconvene the Planning Team to determine the need for a new or revised behavior treatment plan when any emergency measure is used two or more times within a 30-day period, or with an identifiable pattern.

The Support Coordinator is responsible for documenting in the member's case record the outcome of the Planning Team.

Upon receipt of a written report as specified above, the PRC must:

A. Review, evaluate, and track reports of emergency measures taken; and,

B. Report, on a case-by-case basis, instances of excessive or inappropriate use of emergency measures for corrective action to a person designated by the Division.

Physical Management Techniques

Client Intervention Training (CIT) establishes specific techniques to be employed by staff and providers during an emergency to manage a sudden, intense, and out-of-control behavior. These techniques can only be used by persons certified in CIT. Such physical management techniques must:

A. Use the least amount of intervention necessary to safely manage an individual;

B. Be used only when less restrictive methods were unsuccessful or are inappropriate;

C. Be used only when necessary to prevent the member from harming himself/herself or others, or causing severe property damage;

D. Be used concurrently with the uncontrolled behavior;

E. Be continued for the least amount of time necessary to bring the member's behavior under control; and,

F. Be appropriate to the situation to ensure safety.

Persons may be re-certified in CIT when their supervisor determines that there is a need for re-training. This re-training can be accomplished by:

A. Viewing a videotape of the techniques, passing a written test, and demonstrating the techniques to the satisfaction of an instructor; or,

B. Attending the entire CIT course again.

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PREFACE – INTENDED USERS OF THE PROVIDER POLICY MANUAL

REVISION DATE: 2/28/2024, 12/6/2023, 10/1/2021, 7/14/2017,
5/31/2017 EFFECTIVE DATE: May 26, 2017

The Division provides all Home and Community Based Services (HCBS) for members except Physical Therapy for members aged 21 and over and members receiving therapy services through a Multi-Speciality Interdisciplinary Clinic (MSIC). The Division contracts with Health Plans to provide all Behavioral Health services, Physical Health services, Physical therapy to members aged 21 and over, and services provided through an MSIC.

As specified in the table below, the Provider Policy Manual applies to these intended users:

- Tribal Health Program/Fee-For-Service (THP/FFS) providers
- Qualified Vendors/Qualified Vendor Applicants (QV/QVA)
- Acute Health Plans/Administrative Services Subcontractors (Acute/AdSS)
- State-contracted Developmental Homes, through 06/30/2024
- Individual independent providers.

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2 Provider Responsibilities and Expectations		x		x	x
3 Provider Customer Service and Network Support	x	x	x	x	x
4 Covered and Non-Covered Services	x	x	x	x	x
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Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
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17 Prior Authorization Requirements	x	x	x	x	x
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35 Progress Reporting Requirements		x		x	x
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43 Respite Provided at Camp to ALTCS Members		x			
46 Agency With Choice		x			
47 Managing Vendor Call Lists, Vendor Directories, Scope of Services and Reporting Requirements	x	x		x	x

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
48 Credentialing of Contracted Providers		x			x
49 Responsible Driving		x		x	x
50 Vendor Call Requirements for Qualified Vendors		x			
51 Oversight and Monitoring of Developmental Home Services		x		x	
52 Habilitation Staffing Schedule Requirements and Annual Review		x			x
53 Supporting Children in Care of the Department of Child Safety in Community Residential Settings		x		x	
54 Group Home Requirements		x			
57 Third Party Liability Waiver Requests		x			
58 Medication Management Services	x		x		
59 Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services	x		x		
60 Notification to Qualified Vendors		x		x	x
61 Home and Community Based Services (HCBS) Certification and Provider Enrollment	x	x	x	x	x

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
62 Electronic Visit Verification		x			x
63 Workforce Development		x			
64 Preventing Member Abuse, Neglect, and Exploitation		x			
65 Providing Out of State Services		x		x	x
66 Behavioral Health	x	x	x		
67 General and Informed Consent	x	x	x	x	x
68 Advance Directives	x	x	x	x	x
69 Care Coordination	x	x	x	x	x
70 Qualified Vendor Incident Reporting		x		x	x
Appx A QV Provider Instructions - Agency with Choice Option DDD		x			
Appx B Agency with Choice User Guide - FOCUS Vendor Medicaid		x			
Appx C Encounter Data Validation		x	x	x	x

CHAPTER 1 INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATES: 4/10/2024, 1/19/2022, 10/1/2021, 12/13/2017, 5/26/17, 4/16/14

REVIEW DATE: 7/13/2023

EFFECTIVE DATE: March 29, 2013

REFERENCES: A.R.S. § 36-554(A)(10)

PURPOSE

This policy provides Service Providers with an introduction to the Division of Developmental Disabilities.

DEFINITIONS

1. "Case Management" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
2. "Developmental Disability" means as defined in A.R.S. § 36-551.
3. "Home and Community-based Services" or "HCBS" means as defined in A.R.S. § 36-2931.

4. "Individual Independent Provider" means an individual who has a service agreement with the Division to provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP), or Habilitation (HAH/HAI) and who is a DCW.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

6. "Qualified Vendors" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.

7. "Service Provider" means the same as defined in A.R.S. § 36-551.

8. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs through communication and available supports to promote quality, cost-effective outcomes.

9. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. PROGRAM DESCRIPTION

1. The Arizona Department of Economic Security's Division of Developmental Disabilities (Division) provides supports and services for eligible Arizonans diagnosed with one of the following Developmental Disabilities:
   a. Autism;
   b. Cerebral palsy;
   c. Epilepsy;
   d. Cognitive / Intellectual Disability;
   e. Down syndrome; or
   f. Are under the age of six and at risk of having a Developmental Disability.
2. The Division serves individuals who have a qualifying

Developmental Disability and have three documented functional limitations as outlined in Division Eligibility Policy 200-G.

3. The Division's mission is to empower individuals with Developmental Disabilities to lead self-directed, healthy, and meaningful lives.

4. The Division believes that individuals can best be supported in integrated community settings.

5. The majority of the Division's programs and services are tailored to meet the individual needs of individuals with Developmental Disabilities and their families at home and in community-based settings.

6. The Division coordinates services and resources through its central administrative offices, and Case Management through seven districts with local offices located in communities throughout Arizona. The seven districts include:

    a. Central

    b. Early Intervention

c. East

d. North

e. South

f. Specialty

g. West

7. The Division's administrative structure and organizational chart are located on the DDD Homepage on the DES website at:

https://des.az.gov/ddd

B. SUPPORT COORDINATION

1. The primary service that the Division provides directly is Case Management, also called Support Coordination.

2. The Division assigns a Support Coordinator to support each Member based on their eligibility type as outlined in Division Eligibility Manual Chapter 900.

C. HOME AND COMMUNITY BASED SERVICES (HCBS)

1. Home and Community Based Services (HCBS) are delivered through a network of agencies (Qualified Vendors) and Individual Independent Providers throughout Arizona.

    a. HCBS are designed to promote independence and inclusion within the community for eligible Members with Developmental Disabilities and their families, in the least restrictive home and community-based settings.

2. The Division uses the Qualified Vendor Agreement to contract for HCBS services to meet Member needs across the state.

3. The Division certifies HCBS Service Providers and licenses family homes to provide Member care. They also inspect and approve locations where HCBS occur.

D. PHYSICAL AND BEHAVIORAL HEALTH SERVICES

1. The Division also contracts with Health Plans known as Administrative Services Subcontractors (AdSS) that provide statewide physical and behavioral health care to Division Members who are ALTCS eligible and also collaborates with AHCCCS for members who are part of the Tribal Health Program

(THP).

2. The AdSS are responsible for assigning or allowing each person who is enrolled the choice of a primary care provider (PCP).

3. Currently, the contracted AdSS are UnitedHealthcare Community Plan and Mercy Care.

4. The Division is responsible for ensuring that the delivery of physical and behavioral health services meets the needs of Members being served by coordinating care with and providing oversight of the AdSS.

5. Behavioral health services are provided by the Division's contracted AdSS. Crisis services are provided to the Division's ALTCS Members by the Regional Behavioral Health Authority agencies (RBHAs), through a contract with AHCCCS, which receives funding from the legislature.

6. The Division offers a Tribal Health Program (THP) which may be selected as the primary plan by American Indian/Alaska Native (AI/AN) Members. Members who choose THP may receive services through any AHCCCS registered provider. Division AI/AN

Members may also access services from IHS/638 facilities at any time regardless of plan/program enrollment.

E. STATE OPERATED SERVICES

The Division operates a small state operated services program including Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and state operated group home services.

F. QUALITY MANAGEMENT

The Division operates a Quality Management program to ensure health safety and oversight of Members and services.

G. NETWORK OPERATIONS, MANAGEMENT, AND LICENSING

1. The Division's Network Operations Units provide technical assistance to Support Coordinators, Qualified Vendors, and Individual Independent Providers for HCBS.
2. The Network Management Units are responsible for workforce development, development of new HCBS providers, oversight of the contracted HCBS provider network, and the provider network of the contracted Division Health Plans.

3. The Office of Licensing Certification and Regulation (OLCR) completes Life Safety inspections of HCBS service sites, licenses developmental home providers, and certifies Qualified Vendor Agencies and Individual Independent Providers.

2 PROVIDER RESPONSIBILITIES AND EXPECTATIONS

REVISION DATE: 12/27/2023, 04/21/2023, 10/26/2022, 06/29/2022, 10/01/2019, 8/12/2016, 4/16/2014
REVIEW DATE:
EFFECTIVE DATE: March 29, 2013
REFERENCES: RFQVA DDD-2024; 34 C.F.R. § 361.5(c)(9); 34 C.F.R. 361; 42 C.F.R. § 438.100; 45 C.F.R. § 160 and 164; A.A.C R6-6-1001; A.A.C R6-6-1101; Division Medical Policy 1301 and 1302

PURPOSE

This policy outlines the responsibilities and expectations for Division of Developmental Disabilities (Division) service providers. It applies to all Qualified Vendors of Division services.

DEFINITIONS

1. "Business Associate" means a person or entity that provides any of a specifically listed type of service to or for a covered entity; or performs a health plan provider, clearinghouse function, or activity on behalf of a covered entity involving the use or disclosure of Protected Health Information.
2. "Business Day" means the hours between 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding observed state holidays as defined in A.A.C. R2-5A-101.

3. "Center Based Employment" means a structured employment environment to support Members who choose to receive employment services that offer intensive supervision and support for paid work in a work center or in the community. This service provides a healthy, safe, and highly structured work environment to support Members to develop employment skills and refine their career focus. All Members using this service are paid by the Qualified Vendor or employer for work performed in accordance with state and federal law.
4. "Community Residential Setting" means the same as defined in A.R.S. § 36-551.
5. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an individual is compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in

similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions.

6. "Cultural Competency" means the ability to acknowledge and understand the influence cultural history, life experiences, language differences; values and disability have on individuals and families.
7. "Day Services " means a service that engages Members in their communities to develop, or enhance skill development, for activities of daily living and employment while meeting their specialized sensorimotor, cognitive, communication, social interaction, and behavioral needs and foster the acquisition of skills explore their communities, to learn about their interests, to engage with others, and to gain skills needed for greater independence.
8. "Direct Care Worker" or "DCW" means a Direct Support Professional who has passed the required DCW competency

tests and who assists Members with a disability with activities necessary to allow them to reside in their home.

9. "Direct Support Professional" or "DSP" means a person who delivers direct support in Home and Community-Based services with current training according to the training and certification or licensing requirements of the Home and Community-Based Services they provide.
10. "Disability 101" or "DB 101" means an online tool that provides information on benefits, health coverage, and employment to assist Social Security beneficiaries with making informed decisions about going to work.
11. "Group Supported Employment" means a service that provides employment and training activities to support a successful transition to Competitive Integrated Employment or to self-employment to Members employed in integrated businesses and industries in the community using mobile crews, small enclaves, and other small groups.
12. "Health Insurance Portability And Accountability Act" or

"HIPAA" means the Kennedy-Kassebaum Act, signed August 21, 1996, as amended, and as reflected in the implementing regulations as specified in 45 § § C.F.R. Parts 160, 162, and 164.

13. "HIPAA Privacy Rule" means a federal regulation that establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.
14. "HIPAA Security Rule" means a federal regulation that establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
15. "Home and Community-Based Services Final Rule" or "HCBS Settings Rule" means the final rule issued by the Center for Medicare and Medicaid Services that ensures people receiving

HCBS have full access to the benefits of community living and are able to receive services in the most integrated setting. Community Developmental Disability Services are subject to this rule.

16. "Individual Supported Employment" means a service that supports Members to gain or maintain Competitive Integrated Employment or sustainable self-employment by providing job search and job coaching services including assistance in matching the individual with Competitive Integrated Employment, or support for finding meaningful self-employment.
17. "Integrated Community Work Setting" means a worksite that is located in a naturally occurring community of residential, business, social, or educational environments.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family

members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

20. "Qualified Vendor" or "contractor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
21. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.
22. "Residential Services" means, for the purpose of this policy, the same as Community Residential Setting defined in A.R.S. § 36-551, except this policy does not apply to state-operated services.

23. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a Member for whom no guardian has been appointed.
24. "Work Incentive Consultation" means a meeting with a work incentive consultant trained in Social Security, Medicare, AHCCCS, and other government programs, who can help a Member understand Social Security work incentives, disability benefit programs, and how they are impacted by work.

POLICY

A. Qualified Vendors and service providers shall:

1. Use the AHCCCS Provider Enrollment Portal, located on the AHCCCS website to:
    a. Apply to become an AHCCCS registered provider;
    b. Maintain continuous enrollment as an AHCCCS registered provider; and
    c. Access instructions on how to use the portal.

2. Comply with all federal, state, and local laws, rules, regulations, executive orders, and Division policies governing performance of duties under the Qualified Vendor Agreement or other contractual agreements.
3. Meet requirements for professional licensure, certification, or registration.
4. As applicable, have a National Provider Identifier.
5. As applicable, maintain documentation indicating compliance with local fire and sanitation codes and regulations.
6. Submit claims for services only if they comply with the DDD Claims Submission Guide.
7. Ensure that each DSP or DCW meets required training requirements within their scope of practice, including Article 9 as outlined in A.A.C. 6-6-901 et seq. and as required in Division Policy.
8. Ensure that each DSP or DCW completes the following:
    a. Background checks as required in the Qualified Vendor Agreement; and

b. A Criminal History Self Disclosure Affidavit (LCR-1034A FORNA) form annually.

9. Ensure each Member's privacy is protected, in accordance with HIPAA and only disclose protected health information (PHI):
   a. To the Member or Responsible Person, unless required for access or accounting of disclosures;
   b. For treatment, payment, and health care operations;
   c. With opportunity to agree or object (Informal permission by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.)
   d. Incidentally to an otherwise permitted use and disclosure;
   e. For public interest and benefit activities; or
   f. With limited data set for the purposes of research, public health, or health care operations.

10. Follow 45 § C.F.R. 160.203 General Rule and exceptions:
    a. To prevent fraud and abuse related to the provision of or payment for health care;
    b. To ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation;
    c. For state reporting on health care delivery or costs;
    d. For purposes of serving a compelling need related to public health, safety, or welfare, and, if a standard, requirement, or implementation specification under Part 164 of this subchapter is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served;
    e. Ensure the confidentiality, integrity, and availability of all electronic PHI the covered entity or Business Associate creates, receives, maintains, or transmits;
    f. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

g. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this Part; and

h. Ensure compliance with this subpart by its workforce.

i. Adhere to the Member rights as outlined in 42 § C.F.R. 438.100, and in the Division's Operation Policy Manual Chapter 1001-A.

j. Follow the code of conduct outlined in the Qualified Vendor Agreement.

B. Each of the Division's Business Associates shall:

1. Develop and maintain policies and procedures for HIPAA practices;

2. Not use or further disclose PHI other than as permitted or required by the contract or as required by law;

3. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the contract;

4. Report to the Division any use or disclosure not allowed by federal regulation of which the Business Associate becomes

aware;

5. Ensure that any agents or subcontractors with whom PHI must be shared agree to the same restrictions and conditions that apply to the Business Associate;
6. Make PHI available to the Member or Responsible Person;
7. Make PHI available for Responsible Person or Member amendment and incorporate any amendments;
8. Make available the information required to provide an accounting of disclosures; and
9. Make internal practices, books, and records relating to the use and disclosure of PHI available to the Division and Department of Health and Human Services- Office of Civil Rights for the purpose of determining compliance with federal requirements.

C. Qualified Vendors shall meet the following HCBS Setting Final Rule requirements:

1. Provide services in a person centered and culturally competent manner that supports and enhances the Member’s

independence, self-esteem, mutual respect, value, and dignity as outlined in the Division's Provider Policy Manual Chapter 26.

2. Ensure the Member always has access to resources about rights in the event they feel their rights are being violated.
3. Utilize the self-assessment and training tools available on the AHCCCS webpage to ensure compliance to the requirements for the following service settings including:
    a. Day Services
        i. The Qualified Vendor shall ensure that Members have the opportunity to engage with others including individuals with and without disabilities who are not paid staff;
        ii. The Qualified Vendor shall provide services in a service site located in a community setting that includes planned opportunities for interaction with community members, information about resources and the ability to participate in community events based on individual preferences;

iii. The Qualified Vendor shall provide exploration and learning opportunities related to work and volunteer experiences; and

iv. The Qualified Vendor shall support Members in developing relationships of their choice.

b. Integrated Community Work Settings

i. The Qualified Vendor shall ensure Members work alongside workers without disabilities, other than paid staff who are providing services to that individual;

ii. The Qualified Vendor shall ensure Members perform the same tasks with the same expectations that a non-disabled peer would perform for pay; and

iii. The Qualified Vendor shall ensure Members freely participate in the social aspects common to the workplace, including but not limited to, having access to all common areas of the enterprise, eating lunch, and taking breaks together.

c. With respect to facility-based services and these other standards for Integrated Work Settings, the Qualified Vendor shall ensure Members have the choice and opportunity to:

i. Develop products and services which are prepared in the facility but sold or provided out in the general community;

ii. Have alternate schedules for services and activities;

iii. Schedule activities at their own convenience;

iv. Have access to entrances and exits to the setting and any and all areas within the setting;

v. Engage in work and non-work activities that are specific to their skills, abilities, desires, needs, and preferences including engaging in activities with people of their own choosing and in areas of their own choosing (indoor and outdoor spaces); and

vi. Have access to food during breaks and lunch.

d. Center-Based Employment

i. Qualified Vendors shall ensure that Members have the opportunity to engage with others including individuals with and without disabilities who are not paid staff;

ii. Qualified Vendors shall provide services in a service site located in a community setting that includes planned opportunities for interaction with community members, information about resources, and ability to participate in community events based on individual preferences;

iii. Qualified Vendors shall ensure that the setting supports Members' access to daily activities, the physical work or program environment, and that Members choose with whom they wish to interact;

iv. Qualified Vendors shall provide support for transportation training or mobility training as

outlined in the Member's person centered service plan (PCSP);

v. Qualified Vendors shall provide Members with the opportunity to explore, observe, or participate in a variety of work opportunities, including integrated work environments to evaluate appropriateness for progressive employment moves including Competitive Integrated Employment or self employment;

vi. Qualified Vendors shall ensure that the Member has the opportunity to participate in productive and meaningful work and that the job is aligned with the Member's capacities and interests;

vii. Qualified Vendors shall provide orientation, training, and skill development to Members, along with teaching general work skills;

viii. Qualified Vendors shall incorporate Arizona Disability Benefits 101 (DB 101) and Work Incentive Consultation into the Member's plan to reach

employment outcomes;

ix. Qualified Vendors shall maintain ongoing assessments of strengths, areas for improvement, and overall job performance;

x. Qualified Vendors shall, at least annually, consult with the Member's planning team to assess with their support coordinator whether:

1) The service is still applicable for the Member, is meeting the Member's needs, and is advancing the Member's employment outcomes or vision for employment;

2) The Member's employment needs could be better supported, additionally coordinated, through other programs, such as school or with a referral to vocational rehabilitation for employment services;

3) The Member's needs could be met through natural supports, independent volunteer

experiences, technology, or adaptive equipment; or

4) The Member could participate in other employment services to further advance their vision for employment.

e. Group Supported Employment

i. Qualified Vendors shall provide vocational or job related discovery or assessment by providing ongoing monitoring of the performance and general job-related skills of Members to identify both strengths and barriers to maintain and advance employment;

ii. Qualified Vendors shall incorporate DB 101 and Work Incentive Consultation into the Member's PCSP to reach employment outcomes;

iii. Qualified Vendors shall refer Members at their request for a progressive move into Competitive Integrated Employment; and

iv. Qualified Vendors shall provide transportation within the Member's scheduled workday from worksite to worksite and provide support for transportation training or mobility training as outlined in the Member's PCSP.

f. Qualified Vendors offering Community Residential Settings shall:

i. Refer Members who want to work or gain work-related skills to the Planning Team to consider adding an employment service;

ii. Ensure that Member responsibilities and expectations are explained to Members prior to service delivery; and

iii. Ensure Members are provided information about rights in their home as outlined in Division Operations Policy Manual 1001-A.

4. Actively participate in the Member's Planning Team by:

a. Attending Planning Team meetings at the date, time, location, and method when requested by the Responsible

Person;

b. Submitting assessments, including recommendations, to the support coordinator at least five Business Days prior to the scheduled Planning Team meeting;

c. Notifying the Member's support coordinator to request a Planning Team meeting whenever there is a significant change in the Member's status;

d. Writing plans of care or teaching strategies necessary to implement assigned outcomes and submit them as required by the Division;

e. Completing other assignments and action items as determined by the Planning Team;

f. Meeting with the Member and, if applicable, the primary caregiver prior to initiating service and obtaining necessary information about needs and preferences, including cultural and language needs;

g. Ensuring that a pre-service orientation occurs with each DSP or DCW before supporting the Member;

h. Providing services as authorized by the Division;

i. Prohibiting an individual DSP or DCW from providing care for more than 16 hours in a 24 hour period; and

j. Maintaining a Member record that minimally contains:

   i. Contact information for the legally Responsible Person;

   ii. The Member's name;

   iii. The Member's date of birth;

   iv. The Member's AHCCCS identification number;

   v. The Member's emergency contacts;

   vi. Intake information and special needs or preferences of the Member;

   vii. Planning documents, progress reports, behavior support plans;

   viii. Summaries of service documentation progress toward goals;

   ix. Medical information;

x. General consent for routine and emergency medical treatment; and

xi. For Community Residential Settings, requirements outlined in the Division's Provider Policy Manual Chapter 33.

k. Reporting incidents, accidents, and deaths in accordance with the Division's Provider Policy Manual Chapter 70.

3 PROVIDER CUSTOMER SERVICE AND NETWORK SUPPORT

REVISION DATE: 12/21/2022, 07/01/2020, 5/16/2018, 2/14/2018, 5/5/2017, 5/27/2016, 1/29/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

PURPOSE

The purpose of this document is to provide information on the customer service assistance and network support offered by the Division of Developmental Disabilities (DDD) to Qualified Vendors, Independent Providers, and parties interested in providing services to Division Members.

A. CUSTOMER SERVICE CENTER

1. Qualified Vendors and Independent Providers may contact the DDD Customer Service Center by phone at 1-844-770-9500 or by email at DDDCustomerServiceCenter@azdes.gov or DDDCustomerServiceCenter-Providers@azdes.gov for support with the following matters, including but not limited to:
    a. Billing and claims submission to the Division
        i. WellSky support.
        ii. Submitting clean claims.

iii. Entering and resolving claims issues in the Division's Resolution System.

iv. Accessing Division reporting tools.

b. Submitting inquiries or grievances to the Division for resolution.

c. Contracts questions.

d. Health care services questions.

B. PROVIDER NETWORK SUPPORT

1. Qualified Vendors may contact Provider Network Support by email at DDDProviderNetworkSupport@azdes.gov to request support with the following:

   a. Technical assistance with service delivery or provision.

   b. Support with initial development of Qualified Vendor policies related to service delivery.

   c. Review and approval of Qualified Vendor policies.

   d. Readiness review meetings.

   e. Qualified Vendor statewide directory management.

   f. Statewide provider meeting schedules.

2. Independent Providers may contact Provider Network Support by email at ProviderNetworkSupportIP@azdes.gov to request support with the following:
    a. Technical assistance with service delivery or provision.
    b. Reviews for Independent Provider readiness.
    c. Rate assessments.
    d. Technical assistance with fiscal intermediary agency, Public Partnership Limited.

C. NETWORK DEVELOPMENT AND RECRUITMENT UNIT

Qualified Vendors may contact the Network Development and Recruitment Unit at NetworkProviderRecruitment@azdes.gov for assistance with the following:

1. Expansion of services to other geographical areas.
2. Amendments to Qualified Vendor Agreements, to include additional services based on need.

CHAPTER 4 – COVERED AND NON-COVERED SERVICES

REVISION DATES:6/15/2022, 6/9/2017, 10/14/2016, 5/27/2016, 4/1/2015, 8/1/2014, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: A.A.C. Title 9, Chapter 28, Articles 2 and 11, and the AHCCCS AMPM.

PURPOSE

The purpose of this policy is to outline guidelines related to services that are covered and service limitations under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM).

DEFINITIONS

1. "Covered Services" means services that may be provided to members eligible for Medicaid in Arizona
2. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to

assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. <u>"Non-Covered Services" means services that may not be provided to members eligible for Medicaid in Arizona</u>

POLICY

Covered Services

The Division of Developmental Disabilities follows AHCCCS guidelines related to services that are covered and service limitations under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM) Chapter 300, 400, and 1200. Chapter 300 outlines medical services (physical and behavioral health). Chapter 400 outlines Maternal and Child Health services, and Chapter 1200 outlines ALTCS Services and Setting for Members who are Elderly and/or Have Physical Disabilities and/or have Developmental Disabilities. In order to be covered, services must be medically necessary, cost-effective, and federally and state reimbursable as stated in A.A.C. R9, Chapter 22, 28, and 31.

In addition, Medicaid members under the age of 21 are entitled to services provided under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program which includes comprehensive treatment and preventive health care services for both physical and behavioral health conditions and illnesses. For persons eligible for EPSDT, federal law requires coverage of all Medicaid services listed in federal law 42 USC 1396d(a) when the services are medically necessary and cost-

effective- even if the services are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies. Services cannot be denied based on moral and religious grounds. Providers should review the AMPM on the AHCCCS website for further information about covered uncovered services and service limitations.

A. Examples of covered medical services include, but are not limited to:

1. Doctor's Visits
2. Immunizations (shots)
3. Prescriptions (prescription coverage is limited for people who have Medicare),)
4. Lab and X-rays
5. Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services for Medicaid eligible children under age 21
6. Specialist Care
7. Hospital Services
8. Transportation to doctor's visits

9. Emergency Services
10. Podiatry Services Performed by a Podiatrist
11. Pregnancy Care
12. Surgery Services
13. Physical Exams
14. Behavioral Health
15. Family Planning Services
16. Dialysis
17. Glasses (for children under age 21)
18. Vision Exams (for children under age 21)
19. Dental Screening (for children under age 21)
20. Dental Treatment (for children under age 21)
21. Emergency Dental (for adults 21 and older. Up to $1000 per contract year)
22. Hearing Exams (for children under age 21)

23. Hearing Aids (for children under age 21)

B. Examples of covered behavioral health services include, but are not limited to:

1. Behavioral Health Day Programs including supervised day programs, therapeutic day programs, medical day programs;

2. Crisis Services including mobile team services, telephone crisis response, and urgent care Inpatient Services including hospital, sub-acute, and residential treatment;

3. Rehabilitation Services including living skills, cognitive rehabilitation, supported employment, and education support;

4. Health Promotion – Prevention, Education and Medication Training – education and standardized training for the purpose of increasing an individual's behavioral knowledge of a health-related topic such as medication management, the nature of an illness, relapse and symptom management, stress management, parenting skills, and healthy lifestyles;

5. Residential Behavioral Health Services include a range of up to 24hr/day services in a structured living environment for

individuals needing support.

6. Support Services include case management, personal assistance, Family & Peer Support, therapeutic foster care, respite, housing support, interpreter services, transportation, assistance accessing community resources and locating and applying for benefits, child care connections; and

7. Treatment Services - counseling, consultation, assessment and specialized testing, and substance abuse treatment.

C. Examples of covered Home and Community-Based Services (HCBS)

1. In-home services such as Homemaker, attendant care. respite, and habilitation

2. Therapy services such as physical, occupational, and speech

3. Community residential services such as developmental Home and group home

4. Employment Services that are not covered by Rehabilitative Services Administration/Vocational Rehabilitation (RSA/VR)

5. Day Treatment Services

6. Home health nursing services

7. Transportation

D. Institutional Services such as Nursing Home or Intermediate Care Facility

Non-Covered Services

A. Examples of non-covered services for members age 21 years and over:

1. Percussive vest

2. Certain transplants.

B. Examples of non-covered services for members of all ages:

1. Vehicle modification

2. Vehicle lift

3. Daycare

4. Additions to homes

5. Pill crushers

6. Service animals

7. Life coaches

8. Home repairs

9. Rent

10. Medical marijuana

11. Any services provided to members outside the United States

CHAPTER 5 - EMERGENCY ROOM UTILIZATION

REVISION DATE: 2/14/2018, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

Emergency services are provided for the treatment of an emergency medical or behavioral health condition. Emergency medical or behavioral health conditions are defined as an acute condition that, if left untreated, could be expected to result in placing a member's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ/part, or serious harm to another person.

Non-emergent services should be obtained in non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekend, or in a doctor's office.

The following are examples of minor problems when an emergency room should not be used:

- A sprain or strain
- A cut or scrape
- An earache
- A sore throat
- A cough or cold.

Emergency services are covered for all Division Arizona Long Term Care System (ALTCS)-eligible members when there is a demonstrated need, and/or medical assessment services indicate an emergency condition. Prior authorization is not required for emergency services.

The Division views the member's Primary Care Provider (PCP) as the gatekeeper for medical services. Given this, non-emergency services should be addressed by the PCP. Urgent care centers are also available, as appropriate. The Division encourages providers to educate members on appropriate utilization of emergency room and urgent care centers.

Chapter 6 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

REVISION DATES: 6/15/2022, 3/7/2018, 5/26/2017, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 441.56(b)(1), 42 U.S.C. 1396d(a), AMPM, A.A.C. R9-22-205, R9-22-213. AMPM Policy 510, AMPM 430 Attachment A, AMPM 431 Attachment A

PURPOSE

This policy establishes provider requirements for the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Diagnostic" means determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

3. "Early" means in the case of a child already enrolled with an AHCCCS Contractor, as soon as possible in the child's life, or in

other cases, as soon after the member's eligibility for AHCCCS services has been established.

4. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Periodic" means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

6. "Screening" means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

7. "Treatment" means any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening

POLICY

A. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Members age 20 years and under who are eligible for AHCCCS are also eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT). EPSDT offers comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or

behavioral health conditions discovered by screenings. This includes preventive, dental, physical, behavioral health, developmental, rehabilitative and specialty services in accordance with AMPM 430 Attachment A, and AMPM 431 Attachment A).

EPSDT services include, but are not limited to, the coverage of:

1. Inpatient and outpatient hospital services
2. Laboratory and x-ray services
3. Physician and nurse practitioner services
4. Medications and medical supplies
5. Dental services
6. Therapy services
7. Behavioral health services
8. Orthotics and prosthetic devices
9. Eyeglasses
10. Transportation
11. Family planning services

12. Diagnostic, screening, preventive, and rehabilitative services.

EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of 42 CFR 441.58. The Administrative Services Subcontractor (AdSS) shall ensure members receive required health screenings in compliance with AMPM Policy 430 Attachment A and the AMPM Policy 430 Attachment F, which are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life. The service intervals are minimum requirements, and any services determined by a primary care provider (PCP) to be medically necessary shall be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

B. EPSDT Covered Services

All applicable Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing (UB-04) revenue codes are listed in the AHCCCS Rates and Billing webpage found on the AHCCCS website.

Providers are required to utilize national coding standards including the use of applicable modifier(s). Refer to the AHCCCS Medical Coding Resources webpage on the AHCCCS website.

C. EPSDT Visits Include

1. A comprehensive health and developmental history, including growth and development screening [42 CFR 441.56(B)(1)] that includes physical, nutritional, and behavioral health assessments

   Refer to the Centers for Disease Control and Prevention website for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Assessment provided by a PCP

   a. Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention,

b. Nutritional assessment is a separately billable service by PCPs who care for EPSDT age members,

c. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings and on an inter-periodic basis, as determined necessary by the member's PCP,

d. Division also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT members who are underweight or overweight,

e. To initiate the referral for a nutritional assessment, the PCP shall use the AdSS' referral form in accordance with AdSS protocols, and

f. If a member qualifies for nutritional therapy due to a medical condition, the following is covered:

i. For medically necessary WIC-exempt formula

ii. Refer to Arizona WIC Programs Food List,

iii. For medically necessary WIC-exempt formula, the AdSS shall also be responsible for procurement of and the primary funding source for any other nutritional supplementation that is medically necessary.

3. Behavioral Health Screening and Services provided by a PCP

The AdSS covers behavioral health services for members eligible for EPSDT. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment or behavioral health assignment.

4. Developmental Screening Tools used by a PCP

a. Developmental screening is a separately billable service by PCPs who care for EPSDT age members.

b. PCPs who bill for developmental screening shall be trained in the use and scoring of the developmental screening

tools as indicated by the American Academy of Pediatrics (AAP).

c. Any abnormal developmental screening finding shall result in referrals for appropriate follow-up.

d. As specified in AMPM Behavioral Health Practice Tools 210 and AMPM Policy 320-O, a copy of the developmental screening tool shall be kept in the medical record.

e. General Developmental Screening at nine months, 18 months, and 30 months EPSDT visits.

i. General developmental screening shall occur at the 9 months, 18 months, and 30 months EPSDT visits.

ii. Accepted tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life. AHCCCS approved tools include the Ages and Stages Questionnaire, Third Edition (ASQ-3), and the Parents' Evaluation of Developmental Status (PEDS), Birth to Age Eight.

iii. The CPT code 96110 shall be used with EP modifier.

f. Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 months and twenty-24 months EPSDT visits:

i. ASD specific developmental screening should occur at the 18 months and 24 months EPSDT visits. The Modified Checklist for Autism in Toddlers (M-CHAT-r) shall be used.

5. A comprehensive unclothed physical examination

6. Immunizations

a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood as specified in the CDC recommended childhood immunization schedules and as specified in AMPM Policy 310- M, according to age and health history, and

b. For members under age 19 years, unless otherwise noted in AMPM Policy 310-M, providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

c. For adult immunizations, refer to AMPM Policy 310-M.

7. Laboratory tests

a. Laboratory including anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).

b. EPSDT covers blood lead screening and testing appropriate to age and risk. Blood lead testing is required for all members at 12 months and twenty- 24 months of age and for those members between the ages of 24 months through 6 years who have not been previously tested or who missed either the 12-month or 24-month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to responsible person's concerns. Additional screening for children through 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

8. Health education, counseling, and chronic disease self-management

9. Oral Health Screening

   Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant, or nurse practitioner

   Fluoride varnish is limited in a PCPs office to once every six months, during an EPSDT visit for children who have reached six (6) months of age with at least 1 tooth erupted, with recurrent applications up to 2 years of age.

10. Appropriate vision, hearing, and speech screenings

    a. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT periodicity schedule and as medically necessary using standardized visual tools.

    b. Ocular photo screening with interpretation and report, bilateral is covered for children ages 3 through 6 as part of the EPSDT visit due to challenges with a child's ability to

cooperate with traditional chart-based vision Screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one.

c. Automated visual Screening is for vision Screening only, and not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices, and

d. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

11. Tuberculin skin testing, as appropriate to age and risk

Children at increased risk of tuberculosis (TB) include those who have contact with persons who have been:

a. Confirmed or suspected as having TB

b. In jail or prison during the last 5 years

c. Living in a household with an HIV-infected person or the child is infected with HIV.

d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

D. Sick Visit Performed In Addition To An EPSDT Visit

A “sick visit” can be performed at the same time as an EPSDT visit if:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation and Management (E/M) service, and

2. The “sick visit” is documented on a separate note.

History, exam, and medical decision-making components of the separate “sick visit” already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine E/M service, and which does not require additional work and the performance of the key components of a problem-

oriented E/M service is included in the EPSDT visit and should not be reported.

E. Provider Requirements

EPSDT services shall be provided according to community standards of practice in accordance with Section 42 USC 1396d(a) and (r), 1396a(a)(43), 42 CFR 441.50 et seq. and AHCCCS rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Policy 430, Attachment A and AMPM Policy 431, Attachment A).

Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of Screening services.

Providers are required to provide health counseling/education at initial and follow-up visits.

Refer to the specific AdSS regarding PA requirements.

A PCP referral is not required for Naturopathic services.

Additionally, providers shall adhere to the below specific standards and requirements for the following covered services:

1. Breastfeeding Support per AAP recommendation, PCPs will ensure that families receive evidence-based breastfeeding information and support.

2. Immunizations:

   a. All appropriate immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule as specified in the CDC recommended immunization schedules and AMPM Policy 310-M.

      Refer to the CDC website: www.cdc.gov/vaccines/schedules/index.html for current immunization schedules. The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed on www.AZDHS.gov. If appropriate, document in the member's medical record the member/responsible person's decision not to utilize EPSDT services or receive immunizations, and

   b. Providers shall coordinate with the ADHS for the VFC program in the delivery of immunization services.

3. Blood Lead Screening

   a. The ADHS Parent Questionnaire, which was formerly used as part of Screening, is no longer required in this population. However, the questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages. Screening efforts should focus on assuring that these children receive blood lead testing,

   b. Anticipatory guidance to provide an environment safe from lead, shall still be included as part of each EPSDT visit from 6 months through 6 years of age, and

   c. A blood lead test result equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick shall be confirmed using a venous blood sample.

4. Organ and Tissue Transplantation Services Refer to Division Medical Policy 310-DD for information regarding AHCCCS-covered transplants.

5. Metabolic Medical Foods

If an AHCCCS covered member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to Division Medical Policy 310-GG.

4. Nutritional Therapy

   a. AHCCCS covers nutritional therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake,

   b. PA is required from the AdSS for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy,

      i. Medical necessity for commercial oral nutritional supplements shall be determined on an individual basis by the member's PCP or specialty provider, using the criteria specified in this policy. An example

of a nutritional supplement is an amino acid based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty provider shall use the AHCCCS approved form, AMPM Policy 430 Attachment B, to obtain authorization from the AdSS.

1) Attachment B shall indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

    a) The member has been diagnosed with a chronic disease or condition,

    b) The member is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the AAP, and

c) There are no alternatives for adequate nutrition

OR

a) The member had met at least two of the following criteria to establish medical necessity:

- Is at or below the 10th percentile for weight-for- length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.
- Reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age.
- Demonstrated a medically significant decline in weight within

the 3 month period prior to the assessment.

- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

c. Additionally, each of the following requirements must be met:

i. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems).

ii. The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period of no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric

foods would be detrimental to the member's overall health, the provider may submit the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements located in the AMPM Policy 430 Attachment B), along with supporting documentation demonstrating the risk posed to the member, for the AdSS Medical Director or Designee's consideration in approving the provider's prior authorization request.

iii. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater - Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria, and it includes:

1) Initial Requests

Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or

specialty provider, or through consultation with a registered dietitian

Clinical notes or other supporting documentation dated within 3 months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity (The physical assessment must include the member's current/past weight-for-length and BMI percentiles (if member is two years of age or older.)

Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, and as member adherence to the prescribed dietary plan/alternatives attempted.

2) Ongoing Requests

Subsequent submissions shall include a clinical note or other supporting documentation dated within 3 months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

Note: Members receiving nutritional therapy must be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually. Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

5. Oral Health Services

As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health Screening. A Screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy, see AdSS Medical Policy 431.

6. Cochlear and Osseointegrated Implantation

a. Cochlear implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for individuals who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or post-lingual. AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members' candidates for cochlear implants shall meet criteria for medical necessity, including but not limited to, the following indications:

i. A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation,

ii. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation,

iii. No known contraindications to surgery,

iv. Demonstrated age-appropriate cognitive ability to use auditory clues, and

v. The device shall be used in accordance with the FDA approved labeling.

b. Coverage of cochlear implantation includes the following treatment and service components:

i. Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist, or audiologist,

ii. Pre-surgery inpatient/outpatient evaluation by a board-certified otolaryngologist,

iii. Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability,

iv. Pre-operative psychosocial assessment/evaluation by psychologist or counselor,

v. Prosthetic device for implantation (shall be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions),

vi. Surgical implantation and related services,

vii. Post-surgical rehabilitation, education, counseling, and training,

viii. Equipment maintenance, repair, and replacement of the internal/external components or both if not operating effectively. Examples include but are not limited to the device is no longer functional or the used component compromises the member's safety. Documentation which establishes the need to replace components not operating effectively shall be provided at the time prior authorization is sought,

ix. Cochlear implantation requires PA from the AdSS Medical Director, and

c. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA]) AHCCCS coverage of medically necessary services for Osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss, or surgery.

Osseointegrated implantation requires PA from the AdSS Medical Director. Maintenance of the Osseointegrated implants is the same as described above for cochlear implants.

d. Conscious Sedation

The AdSS covers conscious sedation for members receiving EPSDT services.

7. Behavioral Health Services

The AdSS covers behavioral health services for members eligible for EPSDT services as described in Contract and Policy. EPSDT behavioral health services include the services necessary to correct or ameliorate mental illnesses and conditions discovered by the Screening services.

For the diagnosis of behavioral health conditions including, but not limited to Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If

allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

8. Religious Non-Medical Health Care Institution Services

The AdSS covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

9. Care Management Services

The AdSS covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

10. Chiropractic Services

The AdSS covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS to ameliorate the member's medical condition.

11. Personal Care Services

The AdSS covers personal care services, as appropriate, for members eligible for EPSDT services.

12. Incontinence Briefs

Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:

a. The member is over 3 years and under 21 years of age,

b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder,

c. The PCP or attending physician has issued a prescription ordering the incontinence briefs,

d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder,

e. The member obtains incontinence briefs from vendors within the AdSS' network, and

f. PA has been obtained as required by the Division, AdSS, or AdSS' designee. The AdSS may require a new PA to be issued no more frequently than every 12 months. PA for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. PA will be permitted to ascertain that:

i. The member is over 3 years and under 21 years of age,

ii. The member has a disability that causes incontinence of bladder and/or bowel,

iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the AdSS, and

iv. The prescription is for 240 briefs or fewer per month unless evidence of medical necessity for over 240 briefs is provided.

13. Medically Necessary Therapies

AHCCCS covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the Screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

CHAPTER 7 DENTAL/ORAL HEALTH CARE

REVISION DATES: 8/16/2023, 6/24/2022, 11/10/16, 4/15/15, 4/16/14
EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual (AMPM) policies 310-D1, 310-D2, 430 and 431

PURPOSE

The purpose of this document is to provide information to Qualified Vendors regarding the provision of medically necessary dental services for Division of Developmental Disabilities (Division) Members age 21 and older. This document also provides information for medically necessary, routine dental services for Division Arizona Long Term Care System (ALTCS) for Members aged 21 and older and covered medically necessary dental services for Members under 21 years of age.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection as a result of pathology or trauma.
2. "Dental Provider" means:

a. An individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to independently engage in the practice of dentistry as defined in A.R.S. § 32-1202.

b. A dentist as defined in A.R.S. § 32-1201.

c. A dental therapist as defined in A.R.S. § 32-1201.

d. A dental hygienist as defined in A.R.S. § 32-1201.

e. An affiliated practice dental hygienist as defined in A.R.S. § 32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
7. "Simple Restoration" means silver amalgam, or composite resin fillings, stainless steel crowns or preformed crowns.

INFORMATION

A. COVERED DENTAL SERVICES

1. The following services are covered when provided by a licensed Dental Providers for Members who are 21 years of age or older:
   a. Emergency dental services up to $1,000 per Member per Contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
   b. Medical and surgical services furnished by a Dental Provider or Physician Service.
2. The services specified in subsection (b) shall be related to the treatment of the following medical conditions:

a. Acute pain excluding Temporomandibular Joint Dysfunction (TMJ) pain,

b. Infection, or

c. Facture of the jaw.

3. Covered emergency services include:

a. Limited problem-focused examination of the oral cavity;

b. Required radiographs;

c. Complex oral surgical procedures such as treatment of maxillofacial fractures;

d. Administration of an appropriate anesthesia; and

e. Prescription of pain medication and antibiotics.

4. The diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) are not covered except for reduction of trauma.

5. For Members who require medically necessary dental services as a prerequisite to AHCCCS-covered organ or tissue transplantation, covered dental services include:

a. The elimination of oral infections and the treatment of oral disease, which include:

i. Dental cleanings,

ii. Treatment of periodontal disease,

iii. Medically necessary extractions, and

iv. Provision of Simple Restorations.

6. AHCCCS covers the services outlined in subsection (5) of this section only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head is covered.

8. The services outlined in subsection (4), (5), and (7) of this section are not subject to the $1,000 adult emergency dental limit.

9. Dental cleanings are only covered in a hospital setting when performed by a hygienist working under the supervision of a Physician or Dentist Provider for Members who are in an inpatient hospital setting and are experiencing the following:

   a. Placed on a ventilator, or

   b. Physically unable to perform oral hygiene.

10. Services outlined in subsection 9 (a)(b) are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, medical codes are submitted and are not subject to the $1000 adult emergency dental limit.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR MEMBERS AGE 21 AND OLDER

1. Medically necessary emergency dental care and extractions are covered for Members aged 21 and older who meet the criteria for a Dental Emergency.
2. The following services and procedures are covered as emergency dental services:
    a. Emergency oral diagnostic examination, limited oral examination – problem focused;
    b. Radiographs and laboratory services, limited to the symptomatic teeth;
    c. Composite resin due to recent tooth fracture for teeth;
    d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;

e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;

f. Pulp cap, direct or indirect plus filling;

g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative or sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection including:

   i. Periapical and periodontal infections; and

   ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1,000 limit.

C. EMERGENCY DENTAL SERVICES LIMITATIONS FOR MEMBERS AGE 21 AND OLDER

1. The following adult dental services are not covered:

a. Maxillofacial dental services provided by a Dental Provider, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible;

b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;

c. Routine restorative procedures and routine root canal therapy;

d. Treatment for the prevention of pulpal death and imminent tooth loss except:

i. Non-cast fillings;

ii. Crowns constructed from pre-formed stainless steel;

iii. Pulp caps; and

iv. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. AdSS AND FEE-FOR-SERVICE (FFS) PROGRAM RESPONSIBILITIES

1. The AdSS provides the following:

a. Coordination of covered dental services for enrolled AHCCCS Members;

b. Documentation of current valid contracts with Dental Providers who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to be in need of emergency dental services, or Members may self-refer

to a Dental Provider when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. Tribal ALTCS and FFS providers provide the following:

a. Coordination of covered dental services for enrolled AHCCCS Members; and

b. Documentation of Primary Care Provider's initiation of Member referrals to a Dental Provider when the Member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.

3. The annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.

4. Dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
5. AdSS or Tribal Case Manager transferring the Member will notify the accepting entity regarding the current balance of the dental benefit.
6. The relinquishing AdSS will use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A), AMPM Policy 520, Attachment A, and AMPM Exhibit 1620-9 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
    a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;
    b. The Member is not be permitted to carry-over unused benefit from one year to the next; and
    c. Services need to be utilized within a year that begins on October 1st and ends on September 30th.

7. Prior authorization for emergency dental services are not required for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS AGE 21 AND OLDER

1. Emergency dental services of $1,000 per contract year will be covered for AHCCCS Members age 21 and older. Billing of AHCCCS Members for emergency dental services in excess of the $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute services and A.A.C. R9-28-701.10 for ALTCS Members.
2. In order to bill the Member for emergency dental services exceeding the $1,000 limit, the following will occur:
    a. The provider must first inform the Member in a way the Member understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS;
    b. The provider will furnish the Member with a document to be signed in advance of the service, stating that the Member understands that the dental service will not be fully paid by AHCCCS;

c. The document will contain information describing the type of service to be provided and the charge for the service, and

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by AHCCCS.

e. The Member will sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. Facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

   a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

      i. An ambulatory service center, or

      ii. An outpatient hospital.

   b. Anesthesia is required as part of the emergency service.

2. Dental Providers performing General Anesthesia (GA) on Members will use dental codes and the cost will count toward the $1,000 emergency dental limit.
3. Physicians performing GA on Members for a dental procedure will bill medical codes and the cost shall count toward the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. Informed Consent for oral health treatment will be completed at the time of initial examination and will be updated at each subsequent six-month follow-up appointment.
    a. A separate written consent will be completed for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies.
    b. A written treatment plan will be reviewed and signed by both parties, as specified below, with the Member or Responsible Person receiving a copy of the complete treatment plan.
2. All providers will complete the appropriate Informed Consents and treatment plans for AHCCCS Members as listed above, in

order to provide quality and consistent care, in a manner that protects and is easily understood by the Member or Responsible Person. This requirement will extend to all Contractor mobile unit providers.

3. Consents and treatment plans will be in writing and signed and dated by both the provider and the Member or Responsible Person.
4. Completed consents and treatment plans will be maintained in the Members' chart and will be subject to audit.

H. ARIZONA LONG TERM CARE SYSTEM (ALTCS) ADULT DENTAL SERVICES

1. In accordance with A.R.S. § 36-2939, ALTCS Members age 21 or older may receive medically necessary dental benefits up to $1,000 per Member per Contract year (October 1st to September 30th) for diagnostic, therapeutic, and preventative care, including dentures.
2. ALTCS Members under age 21 are eligible for services as specified in AMPM Policy 431.

3. ALTCS Members are also eligible for services as specified in AMPM Policy 310-D1.
4. The services specified in AMPM Policy 310-D1 do not count toward the ALTCS $1,000 limit as they are separate.

I. CONTRACTOR AND TRIBAL ALTCS RESPONSIBILITIES

1. Contractors provide the following:
   a. Coordination of covered dental services for enrolled ALTCS Members;
   b. Documentation of current valid contracts with Dental Providers who practice within the Contractor service area(s);
   c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to be in need of ALTCS dental services, or Members may self-refer to a Dental Provider when in need of dental services;
   d. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS; and

e. Assurance that copies of ALTCS dental policies and procedures have been provided to contracted Dental Providers.

2. Tribal ALTCS and FFS providers provide the following:
   a. Coordination of covered dental services for enrolled AHCCCS Members; and
   b. Documentation of Primary Care Provider's initiation of Member referrals to a Dental Provider when the Member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.
3. The annual ALTCS dental benefit limit is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.
4. The ALTCS Contractor, or Tribal ALTCS Case Manager, transferring the Member will notify the receiving entity regarding the current balance of the ALTCS dental benefit. AMPM Exhibit 1620-9 will be utilized for reporting an ALTCS dental benefit balance.

5. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility also shall not be subject to the ALTCS dental benefit $1,000 limit.
6. Frequency limitations and services that require prior authorization apply. The AdSS will refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies.

J. FACILITY AND ANESTHESIA CHARGES

1. If an underlying medical condition of an ALTCS Member necessitates that the services provided under the ALTCS dental benefit be provided in an ambulatory service center or an outpatient hospital and may require anesthesia, the facility and anesthesia charges are subject to the ALTCS $1,000 limit.
2. Dental Providers performing General Anesthesia (GA) on ALTCS Members will use dental codes and the cost will count toward the ALTCS $1,000 limit.
3. Physicians performing GA on an ALTCS member for a dental procedure will bill medical codes and the cost will count toward the ALTCS $1,000 limit.

K. NOTIFICATION REQUIREMENTS FOR CHARGES TO ALTCS MEMBERS

1. Providers will provide medically necessary services within the ALTCS $1,000 dental benefit allowable amount.
2. If medically necessary services are greater than $1,000, the provider may perform the services as set forth in A.A.C. R9-28-701.10 and R9-22-702, after the following notifications take place:
    a. In accordance with A.A.C. R9-28-701.10 and R9-22-702, the provider will inform and explain to the Member both verbally and in writing, in the Member's primary language, that the dental service requested is not covered and exceeds the ALTCS $1,000 limit.
    b. If the Member agrees to pursue the receipt of services:
        i. The provider will supply the Member a document describing the service and the anticipated cost of the service.
        ii. Prior to service delivery, the Member will sign and date a document indicating that the Member

understands that the Member is responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

L. DENTAL SERVICES FOR MEMBERS AGE 20 AND YOUNGER

1. Members who are Medicaid eligible and age 20 years and younger are covered for the following preventative and restorative dental services:
    a. Examinations,
    b. Cleanings,
    c. Extractions,
    d. Sealants,
    e. X-rays,
    f. Amalgam or resin restorations,
    g. Fluoride varnish, and
    h. Other covered services.

CHAPTER 8 – MATERNITY AND FAMILY PLANNING

REVISIONDATE: 8/22/2018, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: AMPM 410, AMPM 420

Maternity Services

The Division of Developmental Disabilities (Division) ensures the provision of maternity services. These services include, but are not limited to medically necessary preconception counseling, pregnancy identification, medically necessary education and prenatal care for the care of the pregnancy, treatment of pregnancy-related conditions, labor and delivery services, and postpartum care for members. All maternity care services must be provided by qualified physicians, physician assistants, nurse practitioners, certified midwives, or licensed midwives. Refer to Division Medical Policy 410 Maternity Care Services for further information. See AHCCCS AMPM 410 for a complete description of covered maternity services. Members may select or be assigned to a Primary Care Provider (PCP) specializing in obstetrics while they are pregnant. Members who transition to a new AdSS or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

The Division allows women and their newborns to receive 48 hours of inpatient hospital care after a routine vaginal delivery and 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48-hour or 96–hour stay. However, for payment purposes, inpatient limits will apply to the extent consistent with Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Family Planning

The Division ensures the provision of family planning services to delay or prevent pregnancy. Covered family planning services include medical, surgical, pharmacological, laboratory services, and contraceptive devices. Covered family planning services also include Long-Acting Reversible Contraceptives (LARC) which are methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required. Covered services also include the provision of accurate information and counseling services allow members to make informed decisions regarding family planning methods. Refer to Division Medical Policy manual 420 Family Planning for additional information. See AHCCCS AMPM 420 for a complete description of covered family planning services. The AdSS is required to educate their providers on the full scope of available family planning services and how members may maintain them.

Pregnancy Termination and Sterilization services may be covered in accordance with Division Medical Policy 420. For further details, see Division Medical Policy 420.

CHAPTER 9 - PCP ASSIGNMENTS

REVISION DATE: 10/1/2021, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Mercy Care Plan website; Care 1st website; Arizona Physicians, IPA website

The Division of Developmental Disabilities (Division) contracts with two Acute Care Health Plans (Administrative Services Subcontractors (AdSSs) to deliver acute health services for its members. The acute care health plan is responsible for assigning a Primary Care Provider (PCP) to enrolled members. Refer to the health plan's website for information about the PCP assignment process or call the Member Services Department at:

United Community Health Plan: 1-800-445-1638

Mercy Care: 1-800-624-3879

Members who are of American Indian descent may choose to receive acute care services through the Tribal Health Program (THP)/Fee-For-Service (FFS). The Division operates the acute care service delivery system for these members. When a member elects THP/FFS, the Division's Support Coordinator works with the member to select a PCP that provides geographically convenient and culturally appropriate services. For THP questions call THP member services at 602-771-8080.

All Division members can change their PCP at any time. Members enrolled with an acute care contractor should contact the Division Liaison or the health plan's Member Services Unit listed above to execute a PCP change. For questions regarding the THP services contact 602-771-8080.

Chapter 10 REFERRALS TO SPECIALISTS

REVISION DATE: 10/1/2021, 10/1/2019, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

Members served by the Division of Developmental Disabilities (Division), who are AHCCCS eligible (Medicaid and DD/Arizona Long Term Care System [ALTCS]), may be referred to a specialist for their medical needs. The Primary Care Provider is responsible for initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and maintaining the member's medical record.

Referrals to Specialists: Physical Health

Primary Care Providers (PCPs) must deem a specialist referral to be medically necessary. Members served by a Division subcontracted health plan must adhere to AHCCCS and Division criteria and requirements for referral to a specialist for a medical need. This information is in the member handbook for each of the Division's subcontracted health plans.

The Division subcontracted health plan each have their own procedures for referrals to specialists and for authorization. However, referrals to medical specialists must still align with AHCCCS and Division requirements for specialists' referrals as defined in the AHCCCS Medical Policy manual (AMPM).

Any Division Tribal Health Program (THP) member utilizing a non-IHS/638 provider or facility rendering AHCCCS covered services must obtain prior authorization from the Division Prior Authorization Unit for specialist services. Prior Authorization is not required for Fee-for-service (FFS) members receiving services from Indian Health Service/638 (IHS/638) providers and facilities.

For Prior Authorization, providers must be prepared to submit the following information:

A. Provider name and provider ID

B. Member/patient name and AHCCCS ID number

C. Type of specialist/service

D. Service date

E. ICD-10 diagnosis code(s)

F. CPT or CDT procedure code(s) or HCPCS code(s)

G. Anticipated charges (if applicable), and

H. Medical justification.

Division Prior Authorization Unit staff, upon receipt and assessment of information provided, will issue to the requesting provider an approval, a provisional prior authorization number, or notify the provider of a denial of coverage.

Referrals to Specialists: Behavioral Health

Members served by the Division's subcontracted health plan shall be provided coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health services provided by a PCP within their scope of practice, or behavioral health medical provider. The member does not require a referral from the PCP to see a behavioral health medical provider.

Members who are AHCCCS eligible and are also American Indian may access behavioral health services through the Tribal Regional Behavioral Health Authority (TRBHA) or Indian Health Service Facilities.

Coordinating care for Behavioral Health Medication Management

When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be referred to a behavioral health provider for evaluation and/or continued medication management services, Subcontracted Health plans shall require and ensure that the PCP coordinates the referral. If a member is determined to have a Serious Mental Illness (SMI), the PCP shall coordinate the transfer of the member's care to a RBHA or TRBHA provider, as applicable (does not apply for members with SMI who have integrated service delivery). All affected subcontracts shall include coordination of care provisions.

Policies and procedures shall address, at a minimum, the following:

A. Guidelines for PCP referral to a behavioral health provider for medication management,

B. Guidelines for transfer of a member with an SMI determination to a RBHA or TRBHA for ongoing treatment, as applicable,

C. Protocols for notifying entities of the member's transfer, including reason for transfer, diagnostic information, and medication history,

D. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information,

E. Protocols for transition of prescription services, including but not limited to notification to the appropriate entities of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination must ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with the behavioral health provider prescriber and that all relevant member medical information including the reason for transfer is forwarded to the behavioral health provider prior to the member's first scheduled appointment, and

F. Contractor monitoring activities to ensure that members are appropriately transitioned for care.

Statewide Crisis Lines:

- Maricopa County (800) 631-1314, (602) 222-9444, TTY (800) 327-9254
- Northern Arizona (Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties) (877) 756-4090
- Southern Arizona Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties Crisis Line- (866) 495-6735
- Gila River and Ak-Chin Indian Communities Crisis Line- (800) 259-3449

Health Plans:

A. Mercy Care Plan

Member Services:
602-586-1841
1-800-564-5465
Hearing Impaired TTY/TDD 711

Nurse Line:
602-263-3000
1-800-624-3879

B. UnitedHealth Care

Member Services:
1-800-348-4058
TTY: 711
Nurse Line:
1-877-440-0255

Tribal Regional Behavioral Health Authorities (TRBHA)

A. Gila River Regional Behavioral Health Authority

Member Services:
1-888-484-8526, ext. 7010
520-562-3321, ext. 7010
602-528-7100

Crisis Line:
1-800-259-3449

B. White Mountain Apache Regional Behavioral Health Authority

Member Services and Crisis Line:
1-928-338-4811 or
1-877-336-4811

C. Pascua Yaqui Tribe

Member Services:
Tucson: 1-520-879-6060
Guadalupe: 480-768-2000

Crisis Line during Business Hours:
Tucson: 520-879-6060
Guadalupe: 480-768-2000

Crisis Line after hours, weekends, and holidays:
Tucson: 520-591-7206
Guadalupe: 480-736-4943

Coordination of Care

Once a referral is made, the provider will contact the member and/or the responsible person to complete the referral. Division contracted providers may also contact the member's Support Coordinator for assistance. The assigned coordinator will assist in care coordination. When the provider or agency does not have the Support Coordinator's contact information, they may call the Division's Customer Service Center at 844-770-9500. They then provide the Division's operator with the name of the member and the operator will provide the Support Coordinator's information.

CHAPTER 11 ALTCS INQUIRIES, GRIEVANCES, CLAIM DISPUTES, AND APPEALS

REVISION DATE: 6/15/2022, 8/28/2019, 6/23/2017, 11/10/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

PURPOSE

The purpose of this policy is to provide guidelines for provider inquiries, grievances, claim disputes, State Fair Hearings (regarding Notice of Decision), appeals, and State Fair Hearings (regarding Notice of Appeal Resolution). This policy also provides information for providers on member inquiries, grievances, and appeals.

DEFINITIONS

1. “Member Grievance” is an expression of dissatisfaction:
    a. From a member, responsible party, advocate, etc., with any aspect of a member's care other than an adverse benefit determination.
    b. That may pertain to the quality of care or services provided or dissatisfaction with providers, direct care workers, or Division of Developmental Disabilities (Division) staff.
2. “Member Inquiry” means any question related to member matters.
3. “Provider Grievance” means a provider’s expression of

dissatisfaction with an unresolved issue that:

a. May pertain to the quality of care or services provided or dissatisfaction with providers, direct care workers, or Division of Developmental Disabilities (Division) staff.

b. Is not a dispute involving the payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.

4. "Provider Inquiry" means any question related to provider matters or issues that can be resolved within the first call or email or in less than 30 days, and billing issues including claims less than 30 days from the day of billing.

POLICY

A. MEMBER INQUIRIES

1. Member inquiries do not require follow-up as they are addressed on the first communication.
2. If the issue needs additional follow-up for resolution or assistance, it shall be treated as a member grievance.

B. MEMBER GRIEVANCES

1. A member grievance should be resolved within 10 days but no longer than 90 days.
2. To file a grievance, contact:

Division of Developmental Disabilities Customer Service Center

1-844-770-9500 (toll free) or

DDDCustomerServiceCenter@azdes.gov.

3. The Division shall establish procedures to provide a model for handling and tracking of member and provider inquiries, to outline the monitoring of phone call and inquiry standards, and to define the roles and responsibilities.

C. PROVIDER INQUIRIES

1. Provider Inquiries are acknowledged within three days of receipt and resolved in less than 30 days.
2. If resolution is not provided within 30 days, then it shall be elevated as a Provider Grievance.

D. PROVIDER GRIEVANCES

1. Provider Grievance shall be resolved within 30 days.
2. To file a grievance, providers shall contact:

   Division of Developmental Disabilities Customer Service Center at

   1-844-770-9500 (toll free) or

   DDDCustomerServiceCenter@azdes.gov.

E. PROVIDER CLAIM DISPUTES

1. If providers wish to file a claim dispute to maintain their rights, they shall follow the instructions provided below.

2. All providers of services to Division members may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by the Division. The providers may challenge the claim denial or adjudication by filing a formal claim dispute with the Office of Administrative Review.
3. Pursuant to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) Policy 203, all claim disputes challenging claim payments, denials, or recoupments shall be filed in writing no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is later.
4. The claim dispute shall state the factual and legal basis for the relief requested, and shall include all supporting documentation such as claims, remittances, billing detail reports, explanation of benefits, time sheets, medical review sheets, medical records, and correspondence, etc.
5. Incomplete submissions or those that do not meet the criteria for a claim dispute shall be denied.
6. Providers shall mail, email, or fax written claim disputes to:

OFFICE OF ADMINISTRATIVE REVIEW

4000 North Central Avenue

3rd Floor, Suite 301 - Mail Drop 2HE5

PHOENIX ARIZONA 85012

Email: dddofficeofcompliance@azdes.gov

Fax: 602-277-0026

7. If providers have questions, they shall call 602-771-8163 or 1-844-770-9500.
8. The Division shall send the claimant a Notice of Decision within 30 calendar days from the date the claim dispute is received. The Notice of Decision due date may be extended upon mutual agreement between the Division and the provider.

F. STATE FAIR HEARINGS (REGARDING NOTICE OF DECISION)

1. If the providers disagree with the Division's Notice of Decision, they may submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Decision.
2. In the request for State Fair Hearing, providers shall reference the following information:
   a. Re: Request for State Fair Hearing
   b. DDD Claim Dispute Number
   c. Member Name and AHCCCS ID.

3. Providers shall mail, email, or fax written requests for State Fair Hearing to:

   OFFICE OF ADMINISTRATIVE REVIEW

   4000 North Central Avenue

   3rd Floor, Suite 301 - Mail Drop 2HE5

   PHOENIX ARIZONA 85012

   Fax: 602-277-0026

   Email: dddofficeofcompliance@azdes.gov

4. If providers have questions, they shall call 602-771-8163 or 1-844-770-9500.

G. APPEALS

1. Providers may assist members in filing an appeal on their behalf with the member's written permission. The Division does not restrict or prohibit a provider from advocating on behalf of a member. The appeal may be filed verbally or in writing and shall be received by the Division within 60 calendar days from the date of the Notice of Action letter.

2. If the member (or the provider on behalf of the member) believes that the member's health or ability to function will be harmed unless a decision is made in the next three days, the member (or the provider on behalf of the member) may ask for an expedited

appeal.

3. Expedited appeals are resolved within three business days.

4. If the Division does not agree that an expedited appeal is needed, the Division shall notify the provider in writing (when the provider requested the expedited appeal on the member's behalf) and the member within two days. The Division shall also contact the requesting party via telephone. The Division shall decide the appeal within 30 days.

5. Reasons for filing an appeal include:

   a. Denial or limited authorization of a requested service, including the type or level of service

   b. Reduction, suspension, or termination of a previous authorization

   c. Denial, in whole or in part, of payment of a service

   d. Failure to provide service in a timely manner as defined by the State

   e. Failure to act within the timeframes provided in 42 CFP 438.408(b) required for standard and expedited resolution of appeals and standard disposition or grievances

   f. Failure of the health plan to act timely

   g. Denial of a rural enrollee's request to obtain services outside

the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

6. To file a written appeal, member (or the provider on behalf of the member) shall mail, email, or fax the written appeal to:

   OFFICE OF ADMINISTRATIVE REVIEW
   4000 North Central Avenue
   3rd Floor, Suite 301 - Mail Drop 2HE5
   PHOENIX ARIZONA 85012
   Fax: 602-277-0026
   Email: dddofficeofcompliance@azdes.gov

7. To file a telephonic appeal, or if there are any questions, member (or the provider on behalf of the member) shall call 602-771-8163 or 1-844-770-9500.

H. STATE FAIR HEARINGS (REGARDING NOTICE OF APPEAL RESOLUTION)

1. If the member disagrees with the Notice of Appeal Resolution, the member (or the provider on behalf of the member) may submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Appeal Resolution.
2. In the request for State Fair Hearing, the member (or the provider on behalf of the member) shall reference:

a. Re: Request for State Fair Hearing

b. DDD Appeal Number

c. Member Name and AHCCCS ID.

3. The member (or the provider on behalf of the member) shall mail, email, or fax written requests for State Fair Hearing to:

OFFICE OF ADMINISTRATIVE REVIEW

4000 North Central Avenue

3rd Floor, Suite 301 - Mail Drop 2HE5

PHOENIX ARIZONA 85012

Fax: 602-277-0026

Email: dddofficeofcompliance@azdes.gov

4. If the members or providers have questions, they shall call 602-771-8163 or 1-844-770-9500.

12 BILLING AND CLAIM SUBMISSION

REVISION DATE: 04/21/2023, 10/1/2021, 09/15/2021, 9/11/2019, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: CFR 42-433.316; CFR 42-455.410; A.R.S. § 36-551; A.R.S. § 36-2903.01(K); A.R.S. § 36-2903.01(L); A.R.S. § 36-2904(G), A.R.S. § 36-2904(G)(1), A.R.S. § 36-2907; A.R.S. § 36-2931 et seq; A.A.C. R9-29-30; ACOM 201; ACOM 203; ACOM 434

PURPOSE

This policy outlines the requirements for service providers when submitting claims to the Division of Developmental Disabilities (the Division) for services provided to Members eligible for Arizona Long Term Care Services.

DEFINITIONS

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "ALTCS" means the Arizona Long Term Care System.
3. "Internal Control Number" or "ICN" means claim reference number or internal control number unique to each claim and remains the same over the life of the claim.
4. "Clean Claim" means a claim that may be processed without obtaining additional information from the subcontracted

provider of care, from a non-contracting provider, or from a Third Party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

5. "Tribal Health Program" or "THP" means the program that provides medically necessary services for Division enrolled Members. The program provides coverage for acute, preventive, and behavioral health care services.
6. "Evaluation and Management Codes" or "E&M" means a category of Current Procedural Terminology (CPT®) codes used for billing purposes. The majority of patient visits require an E&M code. There are different levels of E&M codes, which are determined by medical decision making, time, and documentation requirements.
7. "Fee for Service" or "FFS" means a method in which doctors and other health care providers are paid for each service performed.
8. "Home and Community Based Services" or "HCBS" means one or more of the following services provided to Members: Attendant Care, Habilitation, Home Health Aide, Home Health Nurse, Occupational Therapy, Physical Therapy, Respiratory

Therapy, Respite Services, Speech-language pathology, and other comparable services as approved by the AHCCCS Director.

9. "International Classification of Diseases 10th revision or "ICD-10" means the diagnosis coding system used by physicians and facilities.
10. "Member" means the same as "Client" prescribed in A.R.S. § 36-551.
11. "Qualified Medicare Beneficiary Only" or "QMB Only" means Qualified Medicare Beneficiary under the federal program but does not qualify for Medicaid.
12. "Service Provider" means a person or agency that provides services to clients pursuant to a contract, service agreement or qualified vendor agreement with the Division.
13. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan.
14. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the

medical expenses incurred by a Member eligible for AHCCCS benefits.

15. "Void" means a reversal of a claim, with the entire claim amount being recouped.

POLICY

A. PROVIDER REQUIREMENTS

All service providers, including but not limited to out-of-state providers, those providing services under a State plan or under a waiver of a plan, attending and servicing providers both within and outside of a hospital setting, and billing providers shall meet the following requirements to be reimbursed for covered services provided to AHCCCS Members:

1. Enroll with AHCCCS;
2. Have an assigned AHCCCS Provider Identification Number; and
3. Register their National Provider Identifier (NPI) if applicable to the service provider type, with AHCCCS.

B. GENERAL BILLING REQUIREMENTS

1. Service providers shall adhere to the billing requirements observed by Medicare, Medicaid, and other Third-Party payers.

2. Service providers shall determine the extent of TPL coverage and bill all Third Party payers, including Medicare, before billing the Division.
3. Service providers shall adhere to applicable prior authorization requirements found in DDD Provider Manual Chapter 17 for all ALTCS/HCBS claims.
4. The service provider shall submit claims only for rendered goods or services.
5. The service provider shall enter their Federal Tax ID number associated with their Division contract on all claims.
6. The service provider shall enter their NPI on all claims, if applicable to the service provider type.
7. The service provider shall not submit claims to the Division if a Member is absent for any service.
8. The service provider shall adhere to the same timely filing and billing format requirements in this policy as is required for submitting initial claims for the following types of claims:
    a. Resubmitted claims;
    b. Corrected claims; and

c. Voided claims.

C. SERVICE DATES AND CLAIMS SUBMISSION TIME FRAMES

1. The service provider shall ensure that the last date of service billed is prior to or on the same date the claim is signed and submitted to the Division if the claim is covering a date range over which the service was provided.
2. The service provider shall submit claims for service rendered dates spanning within one month. If billing for multiple months, the service provider shall submit separate claims for each month.
3. The service provider shall adhere to the following time frames for submitting initial claims to the Division:
    a. No later than six months after the date of service.
    b. No later than six months from the date that eligibility is posted for claims involving retro-eligibility.
4. The service provider shall use the first date the item(s) were delivered to the Member as the date of service for durable medical equipment claims.

5. The service provider shall adhere to the following time frames when submitting corrected claims previously processed by the Division to achieve Clean Claim status:
    a. Within 12 months from the date of service.
    b. Within 12 months from the date eligibility was posted for claims involving retro-eligibility.
    c. Within 60 days of the last adverse action.

D. CLAIMS SUBMISSION REQUIREMENTS

1. The service provider shall refer to the Claims Submission Guides on the Division's website for instructions on submitting claims.
2. The service provider shall submit one of the following types of claims forms:
    a. Single claim entries via the WellSky professional billing system.
    b. Nationally standardized, original paper claim forms:
        i. CMS 1500 Form: For claims for professional services, including long term care and HCBS.
        ii. CMS 1450 (Institutional) or UB-04 Form: For claims for intermediate care facilities, hospital in-patient

and out-patient services, dialysis, hospice, and skilled nursing facility services.

iii. ADA 2012 Form: For claims for dental services.

c. Electronic claim transmittals:

i. 837P (Professional)

ii. 837I (Institutional)

iii. 837D (Dental)

3. Service providers shall submit claims with current code sets from the ICD-10, CPT®, Healthcare Common Procedure Coding System, Current Dental Terminology, and National Drug Codes.

E. BILLING DIVISION MEMBERS

1. Service providers shall not bill Members eligible for Medicaid, including QMB Only Members, for Division-covered services.
2. Service providers shall not bill Members for missed ALTCS/HCBS appointments.
3. Upon verbal or written notice from the Member that the Member believes the claims are to be covered by Medicaid, a service provider shall not do either of the following unless the service provider has verified through AHCCCS that the Member has

been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

a. Charge, submit a claim to,or demand or otherwise collect payment from a Member who has been determined eligible for Medicaid unless specifically authorized.

b. Refer or report a Member who has been determined eligible for Medicaid, to a collection agency or credit reporting agency for the failure of the Member or person, who has been determined eligible, to pay charges for system covered care or services.

F. OVERPAYMENTS AND RECOUPMENTS

1. The service provider shall notify the Division of any overpayment by submitting a replacement claim to the Division to start the recoupment process.
2. The service provider shall refund the Division within 60 days from the date of notification of overpayment.
3. If an adjustment to a claim is needed, the service provider shall attach documentation substantiating the overpayment, such as

an Explanation of Benefits if the overpayment was due to payment received from a Third-Party payer.

4. If it is necessary to void a claim, the entire payment shall be recouped by the Division and the service provider shall not make direct repayment to the Division.
5. Upon recouping payment from an erroneous payment or overpayment, the Division shall generate a remittance advice showing the original allowed amount, and the new (adjusted) allowed amount for the processed claim.
6. The service provider shall not send a check for the overpayment unless otherwise requested by the Division.

G. MEDICAL REVIEW

1. The Division shall conduct medical review of claims to determine the medical necessity, appropriateness, utilization, and quality of services provided.
2. Service providers shall submit additional documentation for claims identified in the Division claims processing system as near duplicate claims to determine whether it is appropriate to

reimburse multiple providers for the same service on the same day for the same Member.

3. The service provider shall submit medical documentation to the Division for near duplicate payments when requesting an override.

H. SOCIAL DETERMINANTS OF HEALTH

1. Service providers shall routinely screen for and document the presence of social determinants of health.
2. The service provider shall include information about social determinants of health in the Member's chart.
3. The service provider shall include social determinants of health ICD-10 diagnosis codes on submitted claims to comply with state and federal coding requirements.
4. Service providers shall remain current in the use of social determinants of health ICD-10 codes.

CHAPTER 13 - UTILIZATION MANAGEMENT

REVISION DATE: 10/1/2021, 5/26/2016, 4/16/2014
EFECTIVE DATE: March 29, 2013
REFERENCES: ACOM 416; 42 CFR 438.240(b)(3)

The Division of Developmental Disabilities (Division) has mechanisms to detect both underutilization and overutilization of services; see 42 CFR 438.240(b)(3).

Physical and Behavioral Health Services

The Division has developed and implemented processes to monitor and report the utilization for both the subcontracted health plans and the Tribal Health Program (THP). The Division's Medical Management committee monitors, on an ongoing basis, the physical health and behavioral health utilization data findings and makes or approves recommendations based on the variances noted.

A. Subcontracted Health Plans

The member's Primary Care Provider (PCP) is the gatekeeper for medical services, for both preventative and primary services. AHCCCS contracts with the Division for the provision for all Medicaid covered services to eligible members and the Division subcontracts out the medical services for eligible members to specific subcontracted health plans. The subcontracted health plans operate as Managed Care Organizations. Utilization management applies to each of the Division's subcontracted health plans who have a process to evaluate and approve or deny health care services, procedures or settings based on medical necessity, appropriateness, efficacy and efficiency. Utilization management includes a process for prior authorization (see Provider Policy Manual Chapter 17), concurrent review (see Provider Policy Manual Chapter 19), retrospective review, and case management.

B. Tribal Health Program (THP) Providers

All THP providers must be registered with AHCCCS, and comply with all federal, state, and local laws, rules and regulations. The providers must also meet AHCCCS requirements for professional licensure, certification or registration including current Medicare certification. For a small number of American Indians with a developmental disability, an acute Fee-For-Service (FFS) payment methodology is used by all THP providers.

For Division members enrolled with THP, prior authorization is required before rendering any service. The Division's Chief Medical Officer (CMO) or Medical Director will review any denials for the THP population for adherence with medical necessity including cost effectiveness and appropriateness. The Division will pay for health assessments, screening tests, immunizations, and health education under the scope of preventative care for THP members.

Division-eligible American Indian members receive behavioral health services through a Regional Behavioral Health Authority (RBHA), a Tribal RBHA (TRBHA), an Indian Health Services (IHS) facility, or a 638 Tribal facility. Behavioral health services include but are not limited to screening, treatment, and assistance in coordinating care among providers.

C. Behavioral Health Providers

AHCCCS-contracted RBHAs/TRBHAs provide services to Division members through an Interagency Service Agreement (ISA) between AHCCCS and the Division. Data is provided to identify behavioral health utilization for care coordination purposes.

Long Term Services and Supports

The Division monitors utilization to identify patterns of underutilization and over-utilization of Long Term Services and Supports (LTSS). This data is reviewed and analyzed for trends so that appropriate remediation can be identified, as necessary.

CHAPTER 16 – REMITTANCE ADVICE, ELIGIBILITY, AND COST SHARING

REVISION DATE: 07/31/2019, 6/27/2018, 5/30/2018, 5/31/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR § 435.1103, A.R.S. § 36-2903, A.R.S. § 36-2904; A.A.C. R9-22-703, A.A.C. R9-29-301; ALTCS DES/DDD Contract YH6-0014 (Amendment 69), AHCCCS Fee-For-Service (FFS) Provider Billing Manual

This policy contains general information related to the Division of Developmental Disabilities (the Division) remittance advice, eligibility, and cost sharing. Policies regarding submission and processing of Long-Term Care services (LTC) and fee-for-service claims can be found in *Chapter 12 of the Division's Provider Manual* and are also communicated to providers via such channels as Provider Vendor Announcements.

In the absence of specific policies, the Division endeavors to follow the Arizona Health Care Cost Containment System (AHCCCS)/the Centers for Medicare and Medicaid Services (CMS) policy guidelines as closely as possible.

Definitions

A. Cost Sharing - The Division's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

B. Dual Eligible Medicare Beneficiaries (Duals) - A Division member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+)

C. Full Benefit Dual Eligible (FBDE) - A Division member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.

D. In-Network Provider - A provider that is contracted with the Division to provide services.

E. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include, Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).

F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.

H. Medicare Part D - Medicare prescription drug coverage.

I. Non-qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in

A.A.C. R9-29-101.

J. Out of Network Provider - A provider that is neither contracted with nor authorized by the Division to provide services to its members.

1. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.

K. Qualified Medicare Beneficiary Only (QMB Only) - A person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.

L. Specified Low Income Medicare Beneficiary (SLMB) - Persons entitled to Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary's Part B premium costs.

M. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

Remittance Advice

Remittance Advice explains the payment and any adjustments made to a payment during the adjudication of claims. The Division supplies a remittance advice document to the provider which provides the member identification number, member name, service code, Provider number, start date, end date, units, rate, payment amount, Third Party Liability (TPL) amount, and claim line identification. The remittance advice includes the formal claim dispute process and the correction/resubmission process for claims.

AHCCCS Prior Quarter Coverage Eligibility

Effective 1/1/2014, AHCCCS is required to expand the time period AHCCCS pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCCS eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

A. Received one or more AHCCCS covered services during the month.

B. Would have qualified for AHCCCS at the time services were received if the person had applied for AHCCCS.

If the applicant is determined to qualify for AHCCCS covered services during any one or more of the three months prior to the month of application, then the individual will be determined to have "Prior Quarter Coverage" eligibility during those months. As a result, the AHCCCS will pay for AHCCCS covered services provided during those months.

AHCCCS will determine whether an applicant meets prior quarter coverage criteria. If the applicant

meets the prior quarter coverage criteria, providers will be required to bill the AHCCCS for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the member of prior quarter coverage eligibility.

Upon notification of prior quarter coverage eligibility, A.A.C. R9-22-703 requires the provider to promptly refund to the member any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full.

Providers failing to reimburse a recipient for any payments made by the recipient will be referred to the AHCCCS Office of Inspector General (OIG) for investigation and action.

For covered services received during the prior quarter which have not yet been reimbursed or billed the provider must submit a claim to AHCCCS.

AHCCCS Managed Care Contractors, including the Division, are not responsible for determining prior quarter coverage or for payment for covered services received during the prior quarter. Claims submitted to Division Managed Care Contractors, including the Division, for prior quarter coverage will be denied.

Providers may submit prior quarter coverage claims for payment to AHCCCS in one of the following ways:

A. The HIPAA compliant 837 transaction

B. Through the AHCCCS on-line claim submission process

C. By submitting a paper claim form.

Billing requirements can be found at:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

All providers, including Regional Behavioral Health Authority (RBHA) and Tribal Regional Behavioral Health Authority (TRBHA) providers must submit a claim directly to AHCCCS. Pharmacy point of sale claims must be submitted to the AHCCCS Pharmacy Benefits Manager, OptumRx.

Prior Period Coverage for Division Member's

The Division provides Prior Period Coverage for the period of time prior to the Title XIX (Medicaid) member's enrollment with the Division during which time the member is eligible for covered services. Prior Period Coverage refers to the time frame from the effective date of AHCCCS eligibility (usually the first day of the month of application) until the date the member is enrolled with the Division. Once AHCCCS eligibility is approved, the Division receives notification from AHCCCS of the member's enrollment. Irrespective of the date of the member's enrollment with the Division, the Division is responsible for payment of all claims for medically necessary covered services, including behavioral health services and services provided by the Integrated RBHA, received during Prior Period Coverage. The Division will receive a Prior Period Coverage capitation for the cost of Prior Period Coverage.

Services received during Prior Period Coverage are paid by the Division. As mentioned above, the time period for Prior Period Coverage is from the effective date of AHCCCS eligibility until the date

of enrollment with the Division. For example, a member submits an AHCCCS application on April 15th, but the application is not approved for eligibility until sometime in May. The date the member is enrolled with the Division is shortly after the date of the eligibility determination approving AHCCCS coverage. The member's AHCCCS eligibility is retroactive to the first day of the month of application even though enrollment with the Division occurs at a later date. In this example, let's use May 10th as the date the member is enrolled with the Division; the member's AHCCCS eligibility is effective beginning April 1st. The Division is responsible for payment of AHCCCS medically necessary covered services retroactive to April 1st. However, the Prior Period Coverage time period is April 1st through May 9th

Hospital Presumptive Eligibility (HPE)

AHCCCS has developed a Hospital Presumptive Eligibility (HPE) process that allows qualified hospitals to temporarily enroll persons who meet specific federal criteria for full Medicaid benefits in AHCCCS immediately. Hospitals will use special features in Arizona's electronic application, Health-e-Arizona Plus (HEAplus), to process HPE applications.

Enrollment for this process is temporary and members are enrolled in Presumptive Eligibility.

Presumptive Eligibility will cover health care services only through the dates of the decision. Presumptive Eligibility coverage is temporary and will stop on the end date determined on the decision unless a full AHCCCS application is submitted.

AHCCCS will pay for AHCCCS covered services provided during this period of enrollment from registered AHCCCS providers. Claims are submitted directly to AHCCCS.

Retro-Eligibility

Retro-eligibility affects a claim when no eligibility was entered in the Division's billing system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

FFS claims are considered timely if the initial claim is received by the Division not later than six months from the Division date of eligibility posting. Claims must attain clean claim status no later than 12 months from the Division date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the date of eligibility posting. This time limit does not apply to adjustments which would decrease the original Division payment due to collections from third party payers.

Cost Sharing

This section defines the Division's cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this section is also to maximize cost avoidance efforts by the Division and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

A. For QMB Duals and Non-QMB Duals, the Division's cost sharing payment responsibilities are dependent upon various factors:

1. Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid

2. Whether the services are received in or out of network (The Division only has responsibility to make payments to AHCCCS registered providers)

3. Whether the services are emergency services, and/or

4. Whether the Division refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. Title 9, Chapter 29, Article 3.

An exception to the Division's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the Division must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Division has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For the Division responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division Provider Manual, Chapter 57 - Third Party Liability.

B. QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their Division Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C.R9-22-2 or A.A.C. R9-28-2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

Division Payment Responsibilities

The Division is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this Policy. Refer to the Division's *Provider Policy Manual, Chapter 4 - Covered, and Non-Covered Services.* These services include:

- Chiropractic services for adults
- Outpatient occupational and speech therapy coverage for adults
- Orthotic devices for adults
- Cochlear implants for adults
- Services by a podiatrist
- Any services covered by or added to the Medicare program not covered by Medicaid.

A. The Division is prohibited from using the 09 coverage code to deny payment for medically necessary services to members who are both Medicare and Medicaid eligible. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and

Medicaid, and shall not be used to deny payment of claims.

B. The Division only has responsibility to make payments to AHCCCS registered providers.

C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the Division's network or prior authorization has been obtained.

D. The Division must have no cost sharing obligation if the Medicare payment exceeds the Division's contracted rate for the services. The Division's liability for cost sharing plus the amount of Medicare's payment must not exceed DDD's contracted rate for the service. There is no cost sharing obligation if the Division has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the Division must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if DDD has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *(Subject to the limits outlined in this Policy)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: **1.** The Medicare copay, coinsurance or deductible, **or** 2. The difference between the Division's contracted rate and the Medicare paid amount.

FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES **Services are covered by both Medicare and Medicaid** *Subject to the limits outlined in this Policy*			
	EXAMPLE 1 (b. In Table 1 above)	**EXAMPLE 2** (b. In Table 1 above)	**EXAMPLE 3** (b. In Table 1 above)
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100

Medicaid rate for Medicare service (The Division's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
THE DIVISION PAYS	**$20**	**$10**	**$50**

F. Non-QMB Duals

A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9, 9 A.A.C. 28, Article 2 from a provider within the Division's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22, Article 2. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

1. Division Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-2, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST <u>NOT</u> PAY:**
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *Subject to the limits outlined in this Policy*
Medicaid Only	The provider in accordance with the contract

By both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): 1. The Medicare copay, coinsurance or deductible, **or** 2. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (The Division's contracted rate).

2. Division Payment Responsibilities (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracted provider the following applies (Table 3):

Table 3 NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION** *Subject to the limits outlined in this Policy*
Medicare Only	Has no responsibility for payment.
Medicaid only and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the Division **has** referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay the lesser of: 1. The Medicare copay, coinsurance or deductible, **or** 2. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

G. Prior Authorization

The Division can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Division is responsible for Medicare cost sharing if the member is a QMB dual, even if the Division determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Division must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Division must cover the cost of the service for QMB Duals.

H. Part D Covered Drugs

For QMB and Non-QMB Duals, Federal and State laws prohibit the use of Medicaid monies to pay for cost sharing of Medicare Part D medications.

CHAPTER 17 - PRIOR AUTHORIZATION REQUIREMENTS

REVISION DATE: 10/1/2021, 5/26/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual

The Division of Developmental Disabilities (Division) adheres to the prior authorization guidelines and timelines available in the AHCCCS Medical Policy Manual. The Division will no longer process requests for prior authorization of medical services after the services are rendered. The Division will process standard authorization requests within 14 calendar days of the physician's order. The Division will process expedited authorization requests within three working days of the physician's order. When the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the expedited process is implemented.

To receive prior authorization for acute care services for a member of the Division who is enrolled with an acute care health plan, providers should contact the prior authorization department of the member's acute care Health Plan.

To receive prior authorization for acute care services for a member of the Division who is enrolled with the Tribal Health Program (THP), providers should contact the Division's Health Care Services Prior Authorization Unit at the contact information below.

Health Care Services/Prior Authorization Unit
3443 North Central Avenue, Suite 600
Site Code 795M
Phoenix, Arizona 85005

(602) 771-8080 phone
(800) 624-4964 toll-free
(602) 238-9294 fax

The following services require prior authorization for members of the Division who are enrolled with THP.

A. Hospital Inpatient Services

Hospital inpatient services include:

1. Routine (regular) hospital care
2. Intensive care and coronary (heart) care
3. Intensive care for newborns
4. Maternity care, including labor, delivery and recovery rooms, and birthing centers
5. Nursery for newborns and infants
6. Surgery, including anesthesiology

7. Emergency mental health or addiction services
8. Medical supplies and equipment
9. Chemotherapy (cancer treatment)
10. Dialysis
11. Laboratory services
12. Pharmacy services and medicines
13. Radiological and medical imaging services
14. Total parenteral nutrition (feeding tube or intravenous feedings).

B. Medication

The THP may pay for medicines prescribed by a doctor (if the medicine is on the formulary).

Members of the Division who are enrolled in the THP can go to the following three places to get their medications:

1. Indian Health Service (IHS) facilities
2. 638 Tribal Facilities
3. Pharmacies that are part of the Med Impact Pharmacy Program.

Physician, dentist, or other health care provider may provide the prescription. Members are encouraged to fill the prescription at the same pharmacy each time. Some medicines require prior authorization (obtaining Med Impact approval first). The AHCCCS Fee-for-Service formulary is a list of approved medications for which the Division will pay; the Division will not pay for medicines that are not on the list.

C. Long Term Care Services

The Division provides care for members who are enrolled with the THP. Institutional care and home and community based services are provided to members of the Division who are enrolled with the THP who are at risk of institutionalization.

The following services are covered:

1. Medical services
2. Institutional services including:
    a. Nursing Facilities (NFs) and Intermediate Care Facilities (ICFs)
    b. Inpatient psychiatric facilities (RBCs) for members under age 21

c. Home and Community Based Services (refer to the Service Approval Matrix on the Arizona Department of Economic Security website)

d. Hospice services

e. Mental health and substance abuse services

f. Medical equipment and medical supplies

g. Speech, physical, occupational therapies (in nursing facilities and alternative residential facilities and as part of HCBS).

D. Other Covered Services

Other covered services include:

1. Cancer treatment, including chemotherapy and radiation
2. Cardiovascular (heart and blood vessel) exams, tests, treatment, and surgery
3. Consultations
4. Critical care (intensive care units)
5. Emergency treatment
6. Female genital exams, treatment and surgery
7. Gastroenterology (intestinal tract and liver) exams, treatment, and surgery
8. General medical care and services
9. Hearing exams and services
10. Home services and home health services
11. Immune system exams and testing and treatment of immune disorders
12. Laboratory tests
13. Male and females genital system exams, treatment, and surgery
14. Medical/surgical supplies and equipment
15. Musculoskeletal (bone, joint, and muscle) exams, treatment and surgery
16. Nursing services
17. Nutrition therapy
18. Office visits
19. Orthopedic shoes and orthotics

20. Osteopathic treatment
21. Pulmonary (lung and breathing) exams, treatment, surgery, and rehabilitation
22. Radiology (ultrasound, x-rays, other scans)
23. Respite care
24. Speech testing and services
25. Surgical procedures
26. Telehealth services
27. Urinary system exams, treatment, and surgery.

E. Dental Services

The Division covers dental services provided by a licensed AHCCCS-registered dentist.

1. Covered dental services for children include:
    a. Check-ups and sealants (prevention against cavities)
    b. Emergency dental services
    c. All medically necessary therapeutic dental services, including fillings.
2. Covered services for adults include medical and surgical services furnished by a licensed AHCCCS registered dentist only to the extent that such services:
    a. May be performed under state law by either a physician or by a dentist (Adult dental services including anesthesia up to $1,000 from October 1st through September 30th, starting CYE 2017) and
    b. Would be considered physician services if furnished by a physician.

F. Dialysis Services

The THP pays for dialysis at certain Medicare-certified hospitals and Medicare-certified End Stage Renal Disease (ESRD) facilities and includes all medically necessary services, supplies, and testing (including regular laboratory testing).

G. Vision Services

The THP pays for vision services provided by ophthalmologists and optometrists. There are limits based on the member's age and eligibility.

H. Transportation for Medical Appointments

The AIHP pays for non-emergency medical transportation to and from covered medical appointments. A doctor or other health care provider may need to obtain approval (prior authorization) from the Division before transport.

I. Transportation From a Hospital to Another Facility

Prior authorization is required for round-trip ground ambulance transportation for members who require a transfer to another facility for special services if:

1. Use of any other type of transportation may be unsafe

2. Unable to obtain the needed services at the hospital where a member is currently located.

AHCCCS-contracted behavioral health providers must identify, and communicate to their subcontracted providers and eligible members, any behavioral health services that require authorization and the relevant clinical criteria required for authorization decisions.

The Service Approval Matrix for prior authorizations for Home and Community Based Services can be found on the Arizona Department of Economic Security website. Provider claims cannot exceed the hours documented on the *ALTCS Member Service Plan (DDD 1500A)*. Providers must deliver services/tasks based on the member's Planning Document including the Service Evaluation.

CHAPTER 18 - MEDICAL CLAIMS REVIEW

REVISION DATES: 6/15/2022; 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.210(b); 42 CFR 455.410; 42 CFR 447.26; Fee-For-Service (FFS) Billing Manual Chapter 4; Division of Developmental Disabilities (Division) Provider Manual Chapter 12.

PURPOSE

The purpose of this policy is to outline the requirements for Medical Claims Review by the Division or its subcontracted Health Plans.

DEFINITIONS

1. "Clean Claim" means the same as in A.R.S. § 20-3101(2).
2. "Health Care Acquired Condition (HCAC)" means a condition occurring in any inpatient hospital setting that has negative consequences for the member.
3. "Other Provider Preventable Condition (OPPC)" means a condition occurring in any health care setting that has a negative consequence for the members.
4. "Prior Authorizations (PA)" means a process by which the Utilization team assesses in advance whether a service that

requires prior approval will be covered, based on the initial information received.

5. "Provider Preventable Condition (PPC)" means a condition that is defined by both "Other Provider Preventable Condition" and "Health Care Acquired Condition."
6. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

POLICY

A. MEDICAL REVIEW

1. The Division's Claims Department shall perform medical review:
   a. To determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services; and
   b. To audit appropriateness, utilization, and quality of the service provided.
2. To perform the medical review, the Division may ask the providers to submit additional documentation.

3. The Division may review any and all claims for eligible members who were provided covered services for which a provider is requesting or has requested payment from the Division.

B. MEDICAL REVIEW PROCESS

1. The Division shall ensure that medical claims are reviewed by health care professionals who have the clinical expertise and appropriate credentials to complete the review.
2. The medical claims review process for physical and behavioral health services paid for by the Divisions subcontracted health plans shall be completed by the Division's subcontracted Health Plans. [Please see the Health Plans' provider manual on the health plan website for more information.]

C. REQUIREMENTS

1. All claims shall meet the Division requirements for claims submission.
2. If no medical documentation is submitted after receiving a request from the Division, the adjudication staff shall deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with the Medical Review denial code "MD008 - Resubmit with progress notes."

Providers shall not receive a letter requesting documentation because the denial codes are very specific as to what is required.

3. The Division may ask for additional information to complete the claims process.
4. Providers shall not submit the following unless specifically requested to do so:
   a. Emergency admission authorization forms
   b. Patient follow-up care instructions
   c. Nurses' notes
   d. Blank medical documentation forms
   e. Consents for treatment forms
   f. Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
   g. Ultrasound/X-ray films
   h. Medifax information
   i. Nursing care plans
   j. DRG/Coding forms
   k. Medical documentation on prior authorized procedures/hospital stays (Exception: claims that qualify for outlier payment.)

l. Entire medical records

D. DENIALS

1. Medical claims denials shall be sent to the Division Medical Director for review.
2. Provider Preventable Conditions Guidelines

   Title 42 CFR 447.26 prohibits payment for services related to Provider-Preventable conditions.

   a. If during the concurrent review process, an OPPC, HCAC, or PPC is discovered, a Quality of Care (QOC) shall be completed.

   b. The incident shall be reported to the Medical Director or designee and the claims department.

   c. The Division may not pay for services provided without prior authorization.

E. CLAIM SUBMISSION AND PROVIDER ENROLLMENT

Pursuant to the 42 CFR 455. 410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) shall require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers. All providers, including, but not limited to out-of-state

providers, attending and servicing providers both within and outside of a hospital setting, and billing providers shall be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

F. RECONCILING PAID CLAIMS

Payment information, including payment status, shall be provided by the Division. Providers shall review and reconcile the remittance advice payment information and accompanying payments.

G. TIME FRAME FOR INITIAL BILLING SUBMISSION AND RESUBMISSIONS

1. Claims for services rendered shall be received by the Division no later than six months after the date of service as indicated on the claim.
2. Claims shall be submitted within the specified time period from the date of service for the first submission to retain appeal rights, whether the Third Party Liability (TPL) insurance explanation of benefits has been received or not.
3. A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than 12 months after the date of service shown on the original claim.

a. Providers shall correct claim errors and resubmit claims to the Division for processing within the 12-month time period from the date of service.

b. FFS providers shall reconcile denied claims based on the Provider Remittance Advice.

CHAPTER 19 CONCURRENT REVIEW

REVISION DATE: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 447.26, AMPM Chapter 1000

The concurrent review process used by the Division of Developmental Disabilities (Division) includes utilization management activities that occur during an inpatient level of care (physical and behavioral health), rehabilitative level of care, or a skilled nursing facility level of care. The Division's subcontracted acute care health plans perform their concurrent review utilization management activities for Division members enrolled with their health plan during an inpatient level of care, skilled nursing level of care, or home health care services.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided, and it supports the health care provider in coordinating a member's care across the continuum of health care services. Concurrent review decisions are reviews for the extension of previously approved ongoing care.

The concurrent review process includes:

- Obtaining necessary clinical information from facility staff, practitioners and providers
- Using the clinical information provided by facility staff, practitioners and providers to determine benefits coverage
- Notifying facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs at the beginning of the inpatient stay and reassessing these needs throughout the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review
- Identifying members for referral to specialty programs, including specific case management and disease management, behavioral health, and women's health programs.

Concurrent review may be conducted by phone, fax or, as applicable, on-site at the facility where care is delivered.

The Division utilizes InterQual evidence-based criteria in the concurrent review process. These criteria for concurrent review validate the medical necessity for admission and continued stay, and they evaluate quality of care.

The Division prohibits payment for Provider-Preventable Conditions that meet the definition of a Healthcare-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) that may be identified during the concurrent review process (refer to 42 CFR 447.26 or the AMPM Chapter 1000). If an HCAC or OPPC is identified, the Division will report the occurrence to AHCCCS and conduct a quality of care investigation.

Chapter 20 FRAUD, WASTE, AND ABUSE

REVISION DATE: 3/9/22, 10/1/2019, 4/8/2019, 5/26/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: May 19, 2013
REFERENCES: 42 CFR 455.2; A.R.S. §§ 46-451 and 13-3623

PURPOSE

The Division of Developmental Disabilities (Division) is committed to the prevention and detection of fraud, waste, and abuse. Providers are responsible to administer internal controls to guard against fraud, waste, and abuse (FWA). This policy defines FWA and describes procedures for the prevention and detection of FWA, delineates reporting requirements for FWA, describes provider training requirements for FWA, and specifies FWA policy requirements for providers.

DEFINITIONS

1. "Abuse" means the provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program as specified in 42 CFR 455.2.

2. "Code of Federal Regulations (CFR)" means the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

3. "Claim" means Under the False Claims Act (FCA), the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

4. "Deficit Reduction Act (DRA)" means the DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million shall implement written policies for its

employees, management, contractors, and agents regarding the FCA.

5. "False Claims Act (FCA)" means the FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. It is the Federal Government's primary litigation tool in combating fraud against the Government. The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

6. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable Federal or state law. (42 CFR 455.2)

   a. An act of fraud has been committed when a member or provider:

b. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

c. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

d. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

e. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government

7. "Internal Audit Administration (IAA)" means a functional administration within the Department of Economic Security (DES), Office of Inspector General (OIG); Internal Audit Administration (IAA) conducts performance audits of agency systems and programs, and compliance audits of contractors to identify risk, recommend corrective actions to prevent or mitigate issues, recoup improper payments, and assess compliance with laws, regulations, and standards. In addition to

identifying factors inhibiting performance, IAA audits assist in evaluating the effectiveness of programs, activities, and functions; determining whether measures of program effectiveness are valid and reliable; and assessing whether management has considered alternatives that might increase the likelihood of achieving desired results or improve the efficiency or effectiveness of strategies and solutions. The authority to conduct audits of its contracts and subcontracts is derived directly from the Arizona Revised Statute A.R.S. § 35-214.

8. “Prevention” means to keep something from happening.

9. “Provider” means a person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers shall meet the specific qualifications outlined in the Division‘s Policy Manuals. All providers of Arizona Long Term Care System (ALTCS) services shall be registered with the Arizona Health Care Cost System (AHCCCS). Health Plans under contract with the Division are responsible for credentialing acute care providers.

10. “Waste” means as defined by AHCCCS, the overutilization of services, or other practices that, directly or indirectly, result in

unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

POLICY

A. Prevention and Detection

The Division is committed to fostering a culture of compliance which is conducive to preventing and detecting fraud, waste, and abuse by requiring its providers, agents, and subcontractors to provide ongoing training to their employees, and to become knowledgeable about their role in reporting concerns and problems in relation to fraud, waste, and abuse. All providers, agents, and subcontractors are required to report any concerns relating to potential fraud, waste, and abuse, including false claims. This responsibility is intended to allow the Division to monitor and do improvement planning pertaining to false claims processing or other aspects of Corporate Compliance. Any provider, agent, or subcontractor who fails to report properly either through their internal lines of communication, the Division, or to AHCCCS OIG, when that person knows of conduct constituting a violation of the FCA or any other related legal provision in the

Division's Corporate Compliance program, they will be subject to contract action.

As part of the Division's Compliance Program objectives to detect, prevent and remedy potential, incidents of fraud, waste, and abuse, it is the policy of the Division that all providers, agents, and subcontractors, in particular those involved in the provision of services or arranging for the provision of services under government programs including members and providers, to report matters which involve potential violations of this policy. Reports may be made anonymously; the person doing the reporting may request confidentiality and will be protected from any retaliatory action.

B. Division Monitoring

The Division:

1. Reviews all participating providers during the credentialing/certification process (including re-credentialing)
2. Monitors providers for non-compliance with Division contracts, rules, policies, and procedures, in addition to AHCCCS policies.
3. Verifies as part of Prior Authorization (PA):

a. Member eligibility

b. Medical necessity

c. Appropriateness of service being authorized

d. Service being requested is a covered service

e. An appropriate provider referral.

The Division's electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud, waste, and abuse. Some of these edits include member eligibility, covered services, prior authorization, appropriate services codes, dates of services, authorized units and units provided, duplicate claims, approved rates, and utilization.

The Division, with the support of the IAA, conducts post-payment reviews. The Division Post Payment Review guidelines are consistent with statewide standard uniform procedures used to identify, review and correct billing discrepancies. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These Include the review of provider files, such as timesheets, to ensure proper documentation. The Division may refer billing discrepancies to other entities for further action. In cooperation with

other program integrity sources, the Division, at all levels, is committed to preventing and detecting overpayments resulting in the recoupment of monies due to billing discrepancies.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as-needed basis.

If at any time during the above processes, the incidence of fraud, waste, and/or abuse is suspected or discovered, the matter is referred to the Division's Corporate Compliance Unit for review and potential referral to the AHCCCS OIG.

C. Provider Requirements

1. Training and Education

As a condition for receiving payments, providers shall establish written policies, and ensure adequate training and ongoing education for all of its employees (including management), members, and any subcontractors and/or agents of the Provider regarding the following:

a. Detailed information about the Federal False Claims Act,

b. The administrative remedies for false claims and statements,

c. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and

d. The whistleblower protections under such laws.

2. Reporting Fraud, Waste and Abuse

When a provider becomes aware of an incident of potential/suspected fraud, waste, or abuse, the provider shall report the incident to the Division within one business day of becoming aware of the incident.

D. Fraud Contact Information

To report suspected fraud, waste, or abuse of the program, the provider shall make contact with one of the following:

1. DDD Corporate Compliance Unit

a. Phone: 1-877-822-5799.

b. Online:

https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

c. Email: DDDFWA@azdes.gov

d. Or Write to:

e. DES/DDD

Attn: Corporate Compliance Unit

1789 W. Jefferson Street

Phoenix, AZ 85007

2. AHCCCS OIG Fraud Prevention Unit

a. Phone: 602-417-4193

b. Online:

https://azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

3. Provider Fraud:

a. Maricopa County: 602-417-4045

b. Outside Maricopa County: 1-888-487-6686

4. Member Fraud:

a. Maricopa County: 602-417-4193

b. Outside Maricopa County: 1-888-487-6686

5. General Questions:

a. Email: AHCCCSFraud@azahcccs.gov

CHAPTER 21 - FALSE CLAIMS ACT

REVISION DATE: 10/1/2019, 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Public Law 101-12 (Whistleblower Protection Act), Public Law 109-171 (Deficit Reduction Act of 2005); 31 U.S.C. 3729-3733 (False Claims Act)

Overview

This policy provides an overview of key provisions of the False Claims Act (FCA) and related legal requirements as required by the Deficit Reduction Act of 2005 (DRA) for the Division of Developmental Disabilities (Division). This policy defines fraud and describes the expectations for prevention, detection, and reporting of fraud, false claims, and abuse by providers, agents and subcontractors.

Policy Objectives

A. Delineate the False Claims Act

B. Explain the Deficit Reduction Act of 2005

C. Prevent or detect fraud, waste and abuse

D. Describe training requirements

E. Specify policy requirements for providers, agents and subcontractors

Definitions

A. Abuse – Per 42 CFR 455.2, *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

B. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

C. Claim – Under the False Claims Act (FCA), the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

D. Deficit Reduction Act (DRA) –The DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes

annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

E. False Claims Act (FCA) - The FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. It is the Federal Government's primary litigation tool in combating fraud against the Government. The law includes a *qui tam* provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable Federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

a. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

b. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

c. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

d. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government

G. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

H. Prevention - Keep something from happening.

I. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manuals. All providers of Arizona Long Term Care System (ALTCS) services must be registered with the Arizona Health Care Cost System (AHCCCS). Health Plans under contract with the Division are responsible for credentialing acute care providers.

J. Waste - As defined by (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

The Deficit Reduction Act of 2005

The DRA of 2005 imposes the following requirements on any entity that receives or makes at least $5,000,000 annually:

A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the FCA as established under Title 31 of United States Code, to include administrative remedies for false claims and statements, and any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

B. Provide detailed written policies and procedures for detecting and preventing fraud, waste and abuse.

C. Include in any employee handbook for the entity, a specific discussion of the FCA and Whistleblower Protection Act, to include, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

False Claims Act

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if,

and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

As the "whistle blower" is protected under the FCA, the FCA and related law commits that no person will be subject to retaliatory action as a result of their reporting of credible misconduct. Pursuant to the Division's commitment to compliance with the relevant FCA and other applicable laws, no employee can be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the provider, agent or subcontractor solely because of actions taken to report potential fraud, waste and abuse, or other lawful acts by the employee in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

Training

As a condition for receiving payments, the providers must establish written policies, and must ensure adequate training and ongoing education for, all of its employees (including management), members, and of any subcontractors and/or agents of the Provider regarding the following:

A. Detailed information about the Federal False Claims Act,

B. The administrative remedies for false claims and statements,

C. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and

D. The whistleblower protections under such laws.

CHAPTER 22 PHARMACY SERVICES

REVISION DATE: 1/3/2024, 5/11/2022, 7/1/2020, 3/7/2018, 5/26/2017, 6/17/2016, 4/16/2014
REVIEW DATE: 10/27/2023
EFFECTIVE DATE: March 29, 2013
REFERENCES: A.R.S.§ 36-551; AAC R9-21-206.01; AMPM 310-FF; AMPM 310V; AMPM 1024; ACOM 414; 2018 Arizona Opioid Prescribing Guidelines.

PURPOSE

This manual explains how pharmacy services are administered by the Division and the Administrative Services Subcontractors (AdSS) for Division Members and by the Prescription Benefit Manager (PBM) for Tribal Health Plan (THP) Members.

DEFINITIONS

1. "Member" means the same as "client" as defined in A.R.S. § 36-551.

2. "Non-Preferred Drug" means a medication that is not listed on the AHCCCS Drug List. Non-Preferred Drugs require Prior Authorization (PA).

3. "Preferred Drug List" or "PDL" means a list of all the preferred

medications covered by the Division and the AdSS.

SUPPLEMENTAL INFORMATION

Preferred Drug List (PDL)

1. Any Arizona Health Care Cost Containment System (AHCCCS) healthcare provider may prescribe prescription drugs and over-the-counter medications listed on the Preferred Drug List PDL.

2. Prescriptions issued by prescribers should allow for generic substitution, whenever possible for cost effectiveness.

3. The Administrative Services Subcontractors (AdSS) may cover more drugs than are listed but not less than what is listed on the AHCCCS PDL.

4. When the AdSS receives PDL updates from AHCCCS, the updates are reviewed and sent to the Pharmacy Benefits Manager (PBM) for Members enrolled with the AdSS or to OptumRx for Members enrolled in the Tribal Health Program (THP).

5. When the AdSS receives PDL updates from AHCCCS, the

AdSS will post updates to PDL on their websites.

6. Requests for a hard copy of the PDL shall be submitted to the AdSS Customer Service for Division Members or to AHCCCS Customer Service for THP Members.

7. Updates to the PDL are communicated via the AdSS pharmacy and provider newsletters or on the AdSS websites monthly. The updates for Mercy Care Arizona can be found on their website under the provider section, pharmacy services. The updates for United Health Care Community Plan (UHCCP) can be found on their website under plan documents.

8. For medications that are not listed on the PDL, the prescriber must submit the Prior Authorization (PA) request to the AdSS for Division Members or PBM for THP members.

9. The pharmacy benefit shall cover medications, including prescription and Over The Counter (OTC) medications when prescribed by an AHCCCS-registered health care practitioner.

10. Members who are enrolled in the THP may utilize any of the

following network pharmacies to receive their medications:

a. Indian Health Service (IHS) facilities,

b. 638 Tribal Facilities, or

c. Pharmacies that are part of the OptumRx pharmacy network.

Prior Authorization (PA)

1. Some medications require PA or are Non-Preferred. This means the health care practitioner is required to submit documentation or medical records explaining why the medication is medically necessary or why the Member cannot take medication on the PDL.

2. PA requests must be reviewed within 24 hours and if additional information is required, a decision must be rendered within 7 days. A Notice of Adverse Benefit Determination must be mailed to the Member within 3 days. The prescriber will receive a fax of the decision within 24 hours.

3. The AdSS may have PA requests submitted by submitting the request electronically or via fax. The form and information can be found on the AdSS' website.

4. The use of Long-acting opioids requires PA for Members. Per the Arizona Opioid Prescribing Guidelines, providers prescribing long-acting opioids, must document informed consent indicating they have discussed with the Member the risks, and options, and place the documentation in the Member's health record.

Pharmacy Network

Medications may only be filled at AHCCCS registered pharmacies and pharmacies that are part of the AdSS' pharmacy network. Providers may access this information on the AdSS' website under "Find a provider or pharmacy".

Prescriber Monitoring and Education

1. The AdSS monitors the prescribing and dispensing of opioids,

antipsychotics, muscle relaxants, benzodiazepines, sedative hypnotic and stimulant medications for Members enrolled in their plans.

2. Members that are identified as "at risk" may be placed under the exclusive provider or pharmacy program or both.

3. The AdSS will monitor opioid prescribing patterns for concomitant use with benzodiazepine, buprenorphine, or antipsychotics.

4. For Members being prescribed antipsychotic medications, providers must obtain informed consent and place that information in the Member's health record.

Signature of Chief Medical Officer: Anthony Dekker (Dec 29, 2023 15:48 EST)
Anthony Dekker, D.O.

CHAPTER 23 APPOINTMENT STANDARDS

REVISION DATES: 6/15/2022, 1/16/2019, 5/13/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.206, ACOM 415, ACOM 417

PURPOSE

This policy provides information for qualified vendors on AHCCCS appointment accessibility and availability standards for physical and behavioral health services. This policy also provides timeliness and access to care requirements for qualified vendors who provide in-home care services.

DEFINITIONS

1. “Appointment” - means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or service provider in provider and service categories identified below.

2. “Emergency Appointment” - means an appointment that is scheduled the same day or within 24 hours of the member’s phone call or other

notification, or as medically appropriate.

3. "Urgent Care Appointment" - means an appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

Providers shall adhere to all requirements as specified in Qualified Vendor Agreement, Policy, 42 CFR Part 438. The Division shall monitor and report appointment accessibility and availability to ensure compliance with Division standards set forth in the Qualified Vendor Agreement, Division Operations Manual Policy 415 (Provider Network Development and Management Plan Periodic; Network Reporting Requirements) and Division Operations Manual Policy 417 (Appointment Availability, Monitoring and Reporting) and 42 CFR 438.206.

A. General Appointment Standards

1. Appointment Scheduling

   a. For Primary Care Provider (PCP) appointments, members must be provided:

      i. Emergency appointments the same day or within 24 hours of the member's phone call or other notification,

or as medically appropriate.

ii. Urgent care appointments as quickly and efficiently as the member's health condition requires but no later than two business days of the request.

iii. Routine care appointments within 21 calendar days of the request.

b. For specialty provider appointments, members must be provided:

i. Emergency appointments within 24 hours of referral.

ii. Urgent care appointments as quickly and efficiently as the member's health condition requires but no later than two business days from the request.

iii. Routine care appointments within 45 days of referral.

c. For behavioral health services appointments, members must be provided:

i. Urgent need appointments as quickly and efficiently as the member's health condition requires but no later than 24 hours from identification of need.

ii. Routine care appointments, members must be provided:

- Initial assessment within seven calendar days of referral or the request for service.
- The first behavioral health service follows the initial assessment as quickly and efficiently as the member's health condition requires but:
  - For members aged 18 years or older, no later than 23 calendar days after the initial assessment.
  - For members under the age of 18 old, no later than 21 days after the initial assessment.

iii. All subsequent behavioral health services as quickly and efficiently as the member's health condition requires but no later than 45 calendar days from identification of need.

d. For psychotropic medication appointments, members must be provided:

i. The urgency of the need is assessed immediately.

i. If clinically indicated, an appointment is provided with a Behavioral Health Medical Professional within a timeframe that ensures the member does not:

- Run out of needed medications.
- Decline in his/her behavioral health condition before starting medication, but no later than 30 calendar days from the identification of need.

e. For dental appointments, members must be provided:

i. Emergency appointments within 24 hours.

ii. Urgent appointments as quickly and efficiently as the member's health condition requires but no later than three business days of the request.

iii. Routine care appointments within 45 calendar days of the request.

f. For maternity care appointments, members must be provided initial prenatal care appointments:

i. In the first trimester, within 14 calendar days of the request.

ii. In the second trimester, within seven calendar days of the request.

iii. In the third trimester, within three business days of

the request.

iv. High risk pregnancies as quickly and efficiently as the

v. a member's health condition requires, and no later than three business days of identification of high risk by the AdSS or maternity care provider, or immediately if an emergency exists.

2. Transportation

For medically necessary, non-emergent care, transportation must be scheduled so the member:

a. Arrives on time but no sooner than 20 minutes before the appointment.

b. Is not picked up prior to the completion of the appointment.

c. Is not required to wait more than 20 minutes after the conclusion of the appointment for transportation home.

B. In Home Care Services

Provision of In-Home Care Services. Qualified Vendors shall provide In Home Care Services:

a. For existing members within 14 calendar days following assignment of the authorization.

b. For newly eligible members within 30 calendar days following assignment of the authorization.

C. Electronic Visit Verification (EVV)

The Division is using EVV to help ensure, track, and monitor timely service delivery and access to care for members. The list of provider types and services that are mandated to use EVV can be found on the AHCCCS website and includes but is not limited to Attendant Care, Habilitation Nursing, Homemaker, and Respite. See Chapter 62 Electronic Visit Verification for additional information. Refer to AMPM 540 for additional information regarding EVV.

CHAPTER 24 – AMERICAN WITH DISABILITIES ACT

REVISION DATE: 4/16/2014
EFFECTIVE DATE: March 29, 2013

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs receiving federal financial assistance. The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment, public services, public accommodations, and telecommunications. Providers contracted with the Division shall comply with the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964.

CHAPTER 25 – ENROLLMENT VERIFICATION

REVISION DATE: 1/16/2019, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

AHCCCS Online for Health Plans and Providers: All registered AHCCCS providers are eligible to create an account at:
https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

This tool can be used to check eligibility/enrollment.

Providers are expected to verify member's enrollment by requesting the member to present the acute care health plan identification card. If the member is unable to present the acute care health plan identification card, providers may verify enrollment by calling the Division's Health Care Services Member Services Unit at 844-770-9500.

CHAPTER 26 CULTURAL COMPETENCY AND MEMBER AND FAMILY CENTERED CARE

REVISION DATE: 07/26/2023, 9/22/2021, 7/28/2021, 6/10/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: Civil Rights Act of 1964 Public Law § 88-352, 45 CFR 92.4, 42 CFR 438.206(C)(2); ACOM 405.

PURPOSE

This policy defines the Division of Developmental Disabilities (Division) requirements for contracted Qualified Vendors to provide service in a Culturally Competent manner.

DEFINITIONS

1. "Competent" means for the purpose of this policy properly or well qualified and capable.
2. "Culture" means the integrated pattern of human behavior that includes language, thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting

needs and may be influenced by factors such as geographic location, lifestyle, and age.

3. "Cultural Competency" means, for the purpose of this policy at the interpersonal level, to acknowledge and understand the influence of cultural history, life experiences, language differences; values and disabilities have on individuals and families. At the organizational level, cultural competency means to have policies, procedures, standards, and training to support development of a cultural competence of the workforce.
4. "Disability Etiquette" means for the purpose of this policy, respectful ways to communicate with and about people with disabilities. An organization with a positive workplace Culture in terms of Disability Etiquette fosters opportunities for members of the workforce to develop basic understanding and ongoing opportunities to learn and refresh their knowledge.
5. "Family-Centered" means care that recognizes and respects the pivotal role of the family in the lives of Members. It supports families in their natural care-giving roles, promotes normal

patterns of living, and ensures family collaboration and choice in the provision of services to the Member. When appropriate, the Member directs the involvement of the family to ensure person-centered care.

6. "Interpretation" for the purpose of this policy means the act of verbally conveying the content and spirit of the original message, taking into consideration the cultural context.
7. "Language Assistance Service" means services including, but not limited to:
    a. Oral language assistance, including Interpretation in non-English languages provided in the following manner but not limited to:
        i. In-person by Qualified Interpreters,
        ii. Over the phone by Qualified Interpreters,
        iii. Video Remote Interpreting (VRI) by a Qualified Interpreter, or

iv. Use of qualified bilingual or multilingual staff to communicate directly with individuals with Limited English Proficiency.

b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages to and from English; and

c. Taglines.

8. "Limited English Proficiency (LEP)" means for purposes of this Policy, individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

9. "Linguistic Need" means for the purposes of this Policy, the necessity of providing services in the Member's primary or preferred language, including sign language, and the provision of Interpretation and Translation services.

10. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

11. "Prevalent Non-English Language" means a language determined to be spoken by a significant number or percentage of Members who have a Limited English Proficiency, for the purpose of this policy include Spanish, and Navajo.
12. "Person First Language" means communication that emphasizes the individuality, equality and dignity of a person with disabilities in an effort to convey respect by emphasizing that disability is only one aspect of an individual.
13. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone, video remote interpreting (VRI) service, or an on-site appearance:
    a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,
    b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness, and

c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.

14. "Qualified Translator" means for the purpose of this policy, a translator who:

a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

b. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

c. Is able to translate effectively, accurately, and impartially to and from such languages and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

15. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

16. "Translation" for the purpose of this policy means the conversion of written communication, while taking into consideration the

cultural context, content and spirit of the message, while maintaining the original intent.

POLICY

A. CULTURAL COMPETENCY PLAN

1. Qualified Vendors shall have a comprehensive Cultural Competency Plan (CCP) that is inclusive of those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity. This policy defines the requirements for Qualified Vendors to provide services in a Culturally Competent manner,
2. Qualified Vendors shall provide culturally competent services including the use of:
    a. Disability Etiquette and Person First Language when supporting individuals who have disabilities.
    b. Establishing an effective communication strategy when considering acceptance of a referral.

c. Taking reasonable steps to meaningful access to service for individuals with LEP.

d. Providing written information in Prevalent Non-English Languages in its particular service area.

e. Providing Interpretation services at no charge for all non-English languages, not just those identified as prevalent.

B. INTERPRETATION AND TRANSLATION SERVICES

1. Qualified Vendors shall provide Translation and Interpretation services that are accurate, timely, and that protect the privacy and independence of the individual with LEP.
2. The Qualified Vendor shall provide Translation services through a Qualified Translator, and Interpretation services shall be provided by a Qualified Interpreter.
3. The Qualified Vendor shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to use an adult accompanying the Member with LEP for Interpretation in the following situations:

a. When danger is imminent or there is a threat to the welfare or safety of the Member, and no Qualified Interpreter is immediately available.

b. After receiving an offer and recommendation to use a Qualified Interpreter:

   i. The Member with LEP requests the accompanying adult to interpret or facilitate the communication,

   ii. The accompanying adult agrees to provide communication assistance; and

   iii. Reliance on the accompanying adult for assistance is reasonable under the circumstances.

c. Qualified Vendor workforce shall advocate for use of qualified Interpretation services when an adult accompanying the Member is providing communication assistance and:

   i. There is a concern that the Interpretation is not accurate; or

ii. The content of the conversation is potentially inappropriate to be shared or provided with the accompanying adult.

4. Qualified Vendors shall only rely upon minor children for Interpretation assistance:
   a. In an urgent emergency situation when danger is imminent, or there is a threat to the welfare or safety of the Member, and there is no Qualified Interpreter immediately available.
   b. The Qualified Vendor shall follow up with a Qualified Interpreter to verify information after the emergency is over.
5. Qualified Vendor workforce shall not rely upon an accompanying adult or child to provide Translation of any documents to and from English to another language; documents shall only be translated by a Qualified Translator.
6. Qualified Vendors shall use licensed interpreters for the Deaf and the Hard of Hearing and provide auxiliary aids or licensed sign

language interpreters that meet the needs of the Member upon request.

a. Auxiliary aids include but are not limited to:
    i. Computer-aided transcriptions,
    ii. Written materials,
    iii. Assistive listening devices or systems,
    iv. Closed and open captioning; and
    v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

b. The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed American Sign Language (ASL) interpreters, information on auxiliary aids, and the complete rules and regulations regarding the profession of ASL interpreters in the State of Arizona.

c. The Division’s website lists agencies that provide interpreting services that Qualified Vendors can contract to provide language services to Members who speak other languages or use sign language.

7. The Division shall identify Members requiring language support through service planning, vendor call, and service identification processes.

8 Qualified Vendors, after reviewing and accepting an authorization for a Member, shall ensure the Member has access to all services and communication with the Qualified Vendor, from the initial contact through the conclusion of services provided to the Member, in the Member's language, this can be accomplished through:

   a. Identifying Members of their workforce who speak the primary language of the Member, or
   b. Utilizing Qualified Interpreters who are a part of the Qualified Vendor's workforce, or
   c. Providing language accessibility through a subcontracted Qualified Interpreter who communicates in the Member's language, including American Sign Language.

9. Qualified Vendors may be reimbursed by the Division for subcontracting Qualified Interpreting services for non-prevalent languages.
    a. The Division does not reimburse for Interpretation of prevalent languages which are English, Spanish, or Navajo.
    b. Qualified Vendors must bill separately through the claims submission process and by utilizing the Division's Rate Book.

C. CULTURAL COMPETENCY PLAN

Qualified Vendors shall develop and maintain a Cultural Competency Plan which includes:

1. A method to provide Interpretation and Translation services to Members who need them,
2. A method to notify Members with LEP about the availability of language assistance at no cost,
3. A plan to recruit staff who speak languages other than English,
4. A description of staff training on Cultural Competency and how to apply the training when supporting Members,

5. A method to obtain feedback from Members and families to ensure their cultural and individual needs and preferences are respected.
6. Policies which the vendors use to implement the plan must be made available to members.

D. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

Qualified Vendors shall provide Member, Family-Centered, and Culturally Competent care in all aspects of the service. Member and Family-Centered care includes:

1. Recognizing the family as the primary source of support for the Member's health care decision-making process. Service systems and personnel shall be made available to support the Member and family's role as decision makers.
2. Promoting a complete exchange of unbiased information between Members, families, and health care professionals in a supportive manner at all times.

3. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
4. Implementing practices and policies that support the needs of Members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
5. Participating in Member and Family-Centered Cultural Competence Trainings.
6. Encouraging Member-to-Member and family-to-family support and networking.
7. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
8. Acknowledging that families are essential to the Members' health and wellbeing and are crucial allies for quality within the service delivery system.

9. Appreciating and recognizing the unique nature of each Member and their family.

E. SUPPLEMENTAL INFORMATION

The Division of Developmental Disabilities (Division) promotes a Culture of respect and dignity when supporting individuals who have developmental disabilities and their families. The Division values a Competent, diverse provider network capable of effectively addressing the needs and preferences of its culturally and linguistically diverse Members. The Division acts in accordance with contractual obligations and state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352 which prohibits discrimination in government agencies.

27 PEER REVIEW AND INTER-RATER RELIABILITY

REVISION DATE: 3/22/2023, 7/13/2022, 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Division Medical Manual Policies 910, 950, 960, 970, 980 and 1020, Administrative Services Subcontractors Medical Manual Policies 910, 950, 960, 970, 980 and 1020

PURPOSE

This chapter describes the process and the activities in the Peer Review and Inter-Rater Reliability process of the Division of Developmental Disabilities (Division), as they relate to the improvement of healthcare quality, performance, effectiveness and efficiency of members' care.

DEFINITIONS

1. "Inter-Rater Reliability" means the degree of agreement among individuals who make decisions using the same standardized criteria.
2. "Peer Review" means the objective evaluation of the quality of a physician's performance by colleagues in order to ensure that prevailing standards of care are being met.

POLICY

A. A provider may dispute findings or recommendations that could include an action that affects the provider's credentials or contract with the Division.

B. The provider has 30 days to request reconsideration in writing and submit evidence that supports the provider's position to the Division's Chief Medical Officer (CMO). The CMO will review the reconsideration request and respond, in writing, to the provider.

C. If the provider is still not in agreement, the provider may request a second-level review by the DES/DDD Assistant Director. The DES/DDD Assistant Director's recommendation on the dispute will be considered final. The provider will be notified, in writing, of the outcome.

SUPPLEMENTAL INFORMATION

A. PEER REVIEW

The Division has procedures to ensure the Peer Review process evaluates the necessity, quality of care, and use of services provided by a health care provider. All information used in the Peer Review process is kept confidential and is not discussed outside of the Peer Review process, except for implementing recommendations made by

the Peer Review Committee.Confidentiality statements will be signed by all committee members prior to each scheduled meeting and are maintained by the Division. The Division delegates physical and behavioral health services to the subcontracted health plans but retains oversight of their Peer Review process pertaining to services rendered by their network. Both the Division and the subcontracted health plans ensure any actions recommended by the Peer Review Committee allow for state fair hearing rights and appeals to the affected provider. The process includes information on the state fair hearing process, appeals, timeframes requirements, and the availability of assistance with the process. Peer Review is conducted by health care professionals/providers from the same discipline as the provider under review, or by health care professionals/providers who have similar or equal qualifications as the provider under review, who are not in direct economic competition with the health care provider under review. The process compares the health care provider's performance with the performance of peers and with the standards of care and service within the community.

Peer Review may result from cases identified through quality indicators, as well as from the investigation of significant potential and/or actual quality of care concerns. The goal of the Peer Review process is to provide a review process that is consistent, timely, defensible, educational, balanced, fair, useful, and ongoing.

Peer Review recommendations will be included in the credentialing and contracting process for providers.

The provider receives documentation of the findings and recommendations of the Peer Review.

B. INTER-RATER RELIABILITY

Inter-Rater Reliability ensures consistency and congruence in decision-making using standardized criteria in accordance with adopted practice guidelines. Inter-Rater Reliability may be applied to:

1. Level of care determinations

2. Medical necessity determinations

3. Prior authorization, concurrent review, and retrospective review.

The Division ensures that staff involved in these processes are tested at least annually.

Signature of Chief Medical Officer: Anthony Dekker (Mar 13, 2023 15:50 PDT)

Anthony Dekker, D.O.

CHAPTER 28 - MEMBER RIGHTS

REVISION DATE: 5/26/2017, 3/25/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.3(j)(3), 42 CFR 438.100, 45 CFR 164.524 and 526; A.R.S § 36-551.01, A.R.S. § 36-3205.C.1; Division Operations Manual Policy 1001-A; Qualified Vendor Contract

All members have the right to be treated with dignity and respect. The Division of Developmental Disabilities (Division) is committed to protecting the rights of all individuals who are receiving supports and services operated by, supervised by, or financially supported by, the Division. Division contractors must ensure compliance with any applicable federal and state laws that pertain to member rights and ensure that its staff and subcontractors take those rights into account when furnishing services to members. The contractor must ensure all employees are familiar with the information in the references listed above, and the Division's contractual agreements below.

Members have the right to:

A. Request and receive one copy of the member's medical record at no cost to the member and to request that the record be amended or corrected, as specified in 45 CFR 164.524.

B. Have accommodations to actively participate in the provision of services and have physical access to facilities, procedures, and exams.

C. File a grievance and obtain the grievance process in writing.

D. Exercise their rights without the exercise of those rights adversely affecting the way the contractor or its subcontractors treat the member [42 CFR 438.100(c)].

E. Accept or refuse medical care and the right to execute an advance directive.

The Division's contractors and their subcontractors must:

A. Ensure members and individuals with disabilities are annually informed of their right to request the following information and are offered:

   1. An updated member handbook at no cost to the member

   2. A provider directory as described in the AHCCCS Contractor Operations Manual, Policy 404.

      This information may be sent in a separate written communication or included with other written information, such as in a member newsletter.

B. Maintain written policies that address the rights of adult members to make decisions about medical care. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.

C. Provide written information to adult members regarding an individual's rights under state law to make decisions regarding medical care and the health care provider's written policies concerning advance directives including any conscientious objections [42 CFR 438.3(j)(3)].

D. Ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member, and to request that the record be amended or corrected, as specified in 45 CFR 164.526.

CHAPTER 29 ADVISING OR ADVOCATING ON BEHALF OF A MEMBER

REVISION DATE: 11/22/2023, 5/26/2017, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.100, 42 CFR 438.102, 42 CFR 457.1222, Section 1932(b)(3)(A) of the Social Security Act

PURPOSE

The purpose of this document is to outline the context when the Division may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member.

DEFINITIONS

"Member" means the same as "client" as defined in A.R.S. § 36-551.

SUPPLEMENTAL INFORMATION

Pursuant to 42 CFR 438.100, 42 CFR 438.102, 42 CFR 457.1222, and Section 1932(b)(3)(A) of the Social Security Act, the Division of Developmental Disabilities (Division) may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is authorized to receive services from the provider or who is the provider's patient for the following:

1. The Member's health status, medical care, or treatment options including any alternative treatment that may be self-administered;
2 Any information the Member needs in order to decide among all relevant treatment options;
3. The risks, benefits, and consequences of treatment or non-treatment; and
4. The Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

30 CLINICAL PRACTICE GUIDELINES

REVISION DATE: 3/30/2022, 5/8/2019, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 C.F.R. § 438.236; ACOM 416

PURPOSE

The purpose of this document is to provide information for providers on how to access the clinical practice guidelines for the Division of Developmental Disabilities (Division) and its subcontracted health plans.

A. ACCESSING DDD'S CLINICAL PRACTICE GUIDELINES

The Division has developed guidelines for its providers, members, and staff to use when determining medical necessity. The Division reviews these guidelines at least annually. Links to the clinical practice guidelines used by the Division and the Division's contracted health plans are provided on the Current Qualified Vendors and Providers page of the Division's website.

CHAPTER 30 – CLINICAL PRACTICE GUIDELINES

REVISION DATE: May 8, 2019, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

The Division of Developmental Disabilities (Division) has developed guidelines for its providers, members, and staff, to use. The Division reviews these guidelines at least annually and uses them when determining medical necessity.

Links to the clinical practice guidelines (CPGs) used by the Division and the Division's contracted health plans are provided on the Individuals & Families page and the Providers & Vendors/Resources page of the Division's website.

CHAPTER 31 - TRANSITIONING MEMBERS BETWEEN DDD HEALTH PLANS

REVISION DATE: 6/15/2022, 5/26/2017, 4/16/2014EFFECTIVE DATE: March 29,2013

REFERENCES: A.R.S. § 36-2944

Purpose

To outline the process of when and how responsible parties must notify the Division's Member Services Unit of their wish to change Acute Care Health Plans

Definitions

A. Open Enrollment

1. The Division reserves the right to conduct an open enrollment, if deemed necessary, by Division Administration. Members or their responsible parties must notify the Division if they wish to change contractors during open enrollment.
2. If the member does not participate in the annual birth month enrollment choice, and
    a. the member's eligibility is maintained, the member will remain with his/her current Acute Care Health Plan.

B. Change Request

1. A member may request Contractor changes at the following times by calling the DDD member services phone number (see also the AdSS Operations Manual, Policy 401) [42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]:
    a. With cause, at any time, which includes
        i. poor quality of care,
        ii. lack of access to services covered under the Contract, or
        iii. lack of access to providers experienced in addressing the member's care needs [42 CFR 438.56(d)(2)(v)];
    b. Without cause
        i. ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later;
        ii. at least once every twelve (12) months; or
        iii. upon re-enrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.
2. If it becomes necessary to change the Acute Care Health Plan outside of the open/annual birth month enrollment timeframe,
    a. the member/responsible party must contact the Division'

i. Liaison for the current health plan or

ii. the Division's Member Services Unit.

b. This includes facilitating

i. continuity of care,

ii. quality of care,

iii. efficient and effective program operations, and

iv. in responding to administrative issues regarding member notification and errors in assignment.

C. AHCCCS Contractor Operations Manual (ACOM) Policy 402 documents and delineates the rights, obligations and responsibilities of:

1. The member
2. The member's current health plan
3. The requested health plan
4. The Division.

CHAPTER 34 PROVIDER PUBLICATIONS

REVISION DATE: 2/24/2021
EFFECTIVE DATE: Effective upon signature of Amendment #1 RFQVA 710000

As specified in the Qualified Vendor Agreement, 6.3.5.2, the Qualified Vendor shall provide to the Division for review all reports or publications (written, visual, and/or audio communications) which are intended for Division members or applicants for services funded or partially funded by the Division. The preceding sentence does not apply to communications directed to the general public or persons who are not members or applicants for services funded or partially funded under the Qualified Vendor Agreement. In all provider publications, including website content, the Qualified Vendor is responsible for complying with any applicable laws and regulations regarding individual rights and Protected Health Information.

Qualified Vendor Responsibilities

A. Reports or publications requiring review by the Division include but are not limited to:

1. Newsletters
2. Flyers referencing the Division or Division services
3. Fact Sheets
4. Website Content
5. Radio or TV Presentations

B. The following information does not require review by the Division:

1. Changes to office locations, hours, or phone numbers
2. Information regarding staff (Staff Profiles)
3. Links to resources on website
4. Daily/Weekly Emails

C. All submitted reports or publications must be in:

1. Compliance with AHCCCS policy, Division policy, state laws, Provider Manual, and the Qualified Vendor Agreement.
2. An editable word document, not pdf; and,
3. 6^{th} grade or below reading level.
4. Must include the following statement on printed material:

   Under Titles VI and VII of the Civil Rights Act of 1964 (respectively “Title VI” and “Title VII”) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, insert Qualified Vendor name here) prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion,

sex, national origin, age, and disability. The (insert Qualified Vendor name here) must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, the (insert Qualified Vendor name here) must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the (insert Qualified Vendor name here) will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: (insert Qualified Vendor contact person and phone number here) Para obtener este documento en otro formato u obtener información adicional sobre esta política, (insert Qualified Vendor contact person and phone number here)."

D. Audio materials must include the script.

E. The Qualified Vendor shall submit each report or publication to (DDDProviderPublications@azdes.gov) a minimum of 30 calendar days prior to the anticipated date of delivery or publication. The submission will include the following:

1. Email address and phone number for the employee from the Qualified Vendor who can best answer questions regarding the publication.

2. The name of the Qualified Vendor agency as listed on its Qualified Vendor Agreement.

F. If the Qualified Vendor does not receive a response by the 30th calendar day following submission to the Division, the Qualified Vendor may move forward with the publication.

If the Division expresses concern(s) with the information provided on the submitted report or publication, the Division will explain the concern(s) and the Qualified Vendor shall not move forward with the report or publication until the Division and Qualified Vendor have agreed upon a resolution of the concern. If the Division and Qualified Vendor are unable to resolve the concern, the Qualified Vendor may pursue review as provided in A.A.C. R6-6-2117.

Division Responsibilities

A. Upon receipt of the draft report or publication from the Qualified Vendor, the designated Division employee will initiate the review as described above.

B. Failure of DDD to comment on any submitted report or publication does not waive any subsequent action or constitute approval of the report or publication.

CHAPTER 35 PROGRESS REPORTING REQUIREMENT

REVISION DATE: 3/4/2020, 6/26/2019, 9/15/2017, 9/1/2014
EFFECTIVE DATE: July 1, 2013

Progress reports and other documentation must be developed and maintained by the vendor based on the service being provided.

Elements of Progress Reports

A. The Division of Developmental Disabilities (Division) does not require a specific format to be used for progress reports, however the following minimum elements must be included in progress reports:

1. Member Name
2. Member DOB
3. Member ID
4. Vendor Name
5. Vendor ID
6. Service provided
7. Overall progress specific to planning document outcomes,
8. Performance data that identifies the member's progress toward achievement of the established outcomes,
9. Current and potential barriers to achieving outcomes,
10. A written summary describing specific service activities,
11. Additional service specific requirements as specified in Section B and D.

B. The Division does not require progress reports for:

1. Attendant Care
2. Housekeeping
3. Respite
4. Transportation

C. The Division does require that vendors keep data that documents the provision of all services, regardless of whether a progress report is required, and make this data available to the Division upon request.

For clinical services, the treating provider/vendor, with appropriate supervision if applicable, is required to complete a treatment note for every skilled service encounter. The treating provider(s)/supervisor's and the member's responsible person's signature is required every visit.

Progress Reports Submission Instructions

Progress reports must be submitted to the Division's File Transfer Protocol (FTP) site using the PBS/Reports/ProgressReports/In folder unless otherwise specified in the reporting requirements.

All reports must be submitted following this file naming convention: DDDProgressReport_YYYY_MM_PBS_ASSISTID_SVC_SQN.EXT (see table below).

Position	Parameter	Description	Size	Example
1	YYYY	4-digit Year	4	2019
2	MM	2-digit Month	2	02
3	PBS	4 Character PBS Vendor Code	4	ABCD
4	ASSISTID	10 Digit Client ASSIST ID	10	1234567890
5	SVC	Service Code: • 3 Character DDD Code • 4 Character REV Code • 5 Character HCPCS Code	3, 4, or 5	OTA 0111 A9901
6	SQN	3-digit Sequence Number	3	000-999
7	EXT	File Extension	(Varies)	.pdf, .xlsx, .docx

Progress Reports Schedule and Reporting Requirements

The required due dates for progress reports are listed below by service:

A. Monthly Progress Reports

Submit progress reports (due within 10 business days following each month) for:

1. Day Treatment and Training, Child (Summer)
2. Habilitation, Group Home
3. Habilitation, Nursing Supported Group Home
4. Home Health Aide
5. Nursing

Submit written monthly progress reports to the member's PCP or physician of record, and the Division upon request, regarding the care provided to each assigned member.

B. Quarterly Progress Reports (Non-Habilitation Services)

Submit progress reports (due July 15, October 15, January 15, and April 15) for:

1. Center Based Employment

In addition to the minimum requirements of the progress report, document

any calendar month when the member is not engaged in paid work for at least 75% of the scheduled work hours for that member.

2. Day Treatment and Training, Adult

3. Day Treatment and Training, Child (After School)

4. Employment Support Aide

   In addition to the minimum requirements for the progress report, include:

   a. Performance data that identifies the progress of the member toward achievement of the established objectives.

   b. A detailed record of each contact including hours of service with the member.

   c. Detailed information regarding specific employment support activities.

5. Group Supported Employment

6. Individual Supported Employment

   In addition to the minimum requirements of the progress report, include:

   a. A detailed record of each contact with the member

   b. Detailed information about specific job search activities.

7. Nursing

   Provide quarterly written progress reports to the Division's Health Care Services, including a copy of the current signed plan of treatment, the nursing care plan, and copies of all current physician orders.

8. Therapy Services— (Occupational Therapy, Physical Therapy, Speech Therapy)

   <u>Documentation Requirements</u>

   - Initial Evaluation
   - Plan of Care
   - Reevaluation and Plan of Care Recertification
   - Progress Reporting

   The Qualified Vendor must obtain and develop all of the following documentation to establish authorization for an initial request for therapy services:

   <u>Initial Evaluation</u>

   For new authorizations of therapies, if the submitted request documentation is

not signed and dated by the prescribing provider, the request must be accompanied by a valid written order/prescription.

a. Valid evaluation prescriptions must:

   i. Be prescribed by the member's Primary Care Provider (PCP) or attending Physician including Medical Doctor (MD), Doctor Osteopathy (DO), Physician Assistant (PA), or Nurse Practitioner (NP).

   ii. Include the type of therapy (Speech, Occupational, or Physical).

   iii. Include the verbiage, "Evaluation and treatment as recommended by therapy clinician."

   iv. Include a physician's signature dated less than one year ago.

   v. Be written on the prescribing physician's script pad or letterhead.

   vi. Include the prescribing health professional's NPI number with their signature, and a signature that is legible, or which can be validated by comparing to a signature log or attestation statement.

Plan of Care

Requests for initial services must include a plan of care for the dates of service requested, including all of the following:

a. Member's medical history and background

b. Date of onset of the member's condition requiring therapy or exacerbation date as applicable

c. Date of evaluation

d. Session start and stop time

e. Baseline objective measurements based on standardized testing performed or other standard assessment tools

f. Safety risks

g. Member-specific, measurable short and long-term functional goals within the length of time the service is requested

h. Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services

i. Therapy treatment plan/POC to include specific modalities and treatments planned

j. Documentation of member's primary language

k. Documentation of member's age and date of birth

l. Adaptive equipment or assistive devices, as applicable

m. Prognosis for improvement

n. Requested dates of service for planned treatments after the completion of the evaluation

o. Responsible adult's expected involvement in member's treatment

p. History of prior therapy and referrals as applicable

q. Signature and date of treating therapist

r. Signature and date of prescribing provider/ Primary Care Provider

Reevaluation and Plan of Care Recertification

A complete recertification request and plan of care should be submitted 30 days before the current authorization period expires, but no later than the expiration period for the current authorization period. Requests for recertification services must include revised plan of care for the recertification dates of service requested, including all the following:

a. A progress summary (see progress summary documentation requirements), and

b. An updated treatment plan or plan of care for the recertification dates of service requested, including all of the following:

    i. Date therapy services started

    ii. Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan

    iii. Documentation of reasons continued therapy services are medically needed

    iv. Documentation of client's participation in treatment, as well as client and responsible adult's participation or adherence with a home treatment program

    v. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable

    vi. Adaptive equipment or assistive devices, as applicable

    vii. Prognosis with clearly established discharge criteria

    viii. Documentation of consults with other professionals and services or referrals made and coordination of service when applicable

    ix. The updated treatment plan or plan of care must be signed and dated by the therapist responsible for the therapy services.

x. The updated treatment plan or plan of care must be signed and dated by the prescribing provider.

For recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a valid written order/prescription.

Progress Report

The Qualified Vendor shall complete and submit a progress report at least once every 90 days (quarterly) or by the end of the certification timeframe if the plan of care is less than 90 days. A progress report summary, which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:

a. Date therapy started

b. Date the summary completed

c. Time period (dates of service) covered by the summary

d. Member's medical and treatment diagnoses

e. A summary of member's response to therapy and current treatment plan, to include:

f. Documentation of any issues limiting the member's progress

g. Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation

h. An assessment of the member's therapy prognosis and overall functional progress

i. Documentation of member's participation in treatment as well as member or responsible adult's participation or adherence with a home treatment program

j. Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable

k. Documentation of member 's continued need for therapy

l. Clearly established discharge criteria

m. Documentation of consults with other professionals and services or coordination of service when applicable.

n. The progress summary must be signed and dated by the therapist responsible for the therapy services.

9. Transition to Employment.

C. Quarterly Progress Reports (Habilitation Services)

Submit quarterly progress reports (due July 15, October 15, January 15, and April 15) for:

- Habilitation, Communication
- Habilitation, Community Protection and Treatment Hourly
- Habilitation, Individually Designed Living Arrangement
- Habilitation, Music Therapy
- Habilitation, Hourly Support
- Habilitation, Vendor Supported Developmental Home (Child and Adult).

D. Quarterly Progress Reports (Specialized Habilitation Services)

Submit quarterly progress reports to the member's treatment team. At minimum, include:

- DDD Support Coordinator
- DDD Behavioral Health Administration (BHAdministration@azdes.gov)
- Behavioral Health Case Manager
- As necessary, other providers for care coordination

Submit quarterly progress reports (due July 15, October 15, January 15, and April 15) for:

- Habilitation, Early Childhood Autism Specialized
- Habilitation, Consultation
- Consultation, Positive Behavioral Support.

In each quarterly progress report, provide the following information at a minimum:

1. Member Information
    a. Demographics outlined in A and;
        i. Developmental Disability diagnosis or diagnoses
        ii. Behavioral Health diagnosis or diagnoses
        iii. Physical Health diagnosis or diagnoses
    b. Family/Living/Housing
        i. Who is a part of the member's team/family (e.g., parents, siblings, grandparents, foster parents, group home staff, therapists)?

ii. Who lives with the member? Provide a picture of the member's living environment, potential relationships the member has with people living in his/her home, or state if the member lives alone.

iii. Has the member experienced any recent changes in living environment/situation (e.g., removal from family, divorce, adoption, school suspension, family death, auto accident, loss of job/income)?

c. Home/School/Work Information

i. What school does the member attend, if enrolled?

ii. Is the member employed, or does s/he want to be? If so, where, and for how many hours per week?

iii. Does the member volunteer or participate in community activities? If so, explain.

iv. Is the member experiencing any difficulties in these settings?

d. cultural considerations,

e. prenatal and/or developmental history,

f. medical history,

g. sensory, dietary and adaptive needs,

h. sleep patterns,

i. medications

2. Current Behavior Profile and History of Intervention

Include a brief summary supporting the need for the service. Describe what lesser-intensive supports and services have been attempted or used, and whether they were or were not effective; include why or why not.

3. Review of Recent Assessments and Reports

a. Include any recent assessments that have been completed, including, but not limited to:

i. Functional behavior assessment

ii. Skills assessment(s)

iii. Preference assessment (including identified reinforcers)

iv. Cognitive testing.

b. Provide a summary of findings for each assessment (including any relevant graphs, tables, or grids).

4. Intervention Settings and Activities

   a. State intervention settings and activities completed for the quarter. Include a specific narrative description of the intervention activities and the setting(s) completed for each service date (i.e., the narrative would provide a clear picture of what was done).

   b. Identify skill areas targeted, from among the following:

      i. Language/Communication

      ii. Social

      iii. Motor

      iv. Behavior

      v. Mental Health Concerns

      vi. Cognitive

      vii. Development

      viii. Feeding

      ix. Vocational

      x. Adaptive Skills

      xi. Health/Physical

      xii. Other (specify).

   c. Explain targeted goals and objectives, including an operational definition for each behavior and/or skill and how goals/objectives are measured, as follows:

      i. Identify member's baseline and current level of functioning.

      ii. Describe the behavior that the member is expected to demonstrate, including condition(s) under which it must be demonstrated.

      iii. State date of introduction of each goal/objective.

      iv. Estimated date of mastery for each goal/objective.

      v. Specify plan for generalization of the mastered skill/behavior.

      vi. Specify behavior management (behavior reduction and/or skill acquisition) procedures, such as:

         - Antecedent-based interventions (e.g., environmental modifications, teaching interventions)

- Consequence-based interventions (e.g., extinction, scheduling, reinforcement ratio).

d. Describe data collection procedures and progress toward goals, including the use of the behavior measurement (e.g., rate, frequency, duration, latency) that will reflect the increase or decrease of skills or behaviors, including data from both the consultant and any hourly habilitation support service providers, as follows:

i. Display data in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph, including any of the following:

- Medication initiation and/or changes in medications
- Baseline or pre-intervention levels of behavior
- Strategy changes.

ii. Explain how the analysis of the data is used to revise the member's behavior plan to ensure the best outcome for the member.

5. Parent(s)/Caregiver(s) Training

Summarize parent(s)/caregiver(s) involvement and proposed goals/objectives, including a description of:

a. Behavior that the parent(s)/caregiver(s) is expected to demonstrate, including conditions under which they will demonstrate mastery,

b. Date of introduction of each goal/objective,

c. Estimate date of parent's/caregiver's mastery of each goal/objective,

d. Parent(s)/caregiver(s) training procedures,

e. Data collection procedures and progress toward goals (i.e., report goal as met, not met, modified, and include explanation).

6. Service Level Recommendation (if requesting a service extension)

a. Identify number of hours for continued authorization based on identified interventions specific to the member's needs.

b. Provide a clinical summary that justifies the hours requested.

7. Coordination of Care

How has/will this service be coordinated with other services or therapies that the member is receiving from the Division or other sources (e.g., Behavioral Health, Health Plan, Education, Child Welfare)?

8. Transition Plan

Plan for transitioning the member from the service, including:

Transition statement and Individualized discharge criteria developed with specific, realistic, and timely follow-up care coordination recommendations.

a. Plan for maintenance and generalization, including how and when this service will be transitioned to other lesser intensive services

b. Discharge must occur when:

i. Intervention services are no longer recommended.

ii. Measurable improvements are not expected, or progress has plateaued.

iii. Intervention services are primarily educational in nature.

iv. Intervention is primarily vocational or recreationally based.

v. If proposed future intervention is experimental or unproven.

vi. The member has obtained age appropriate abilities in targeted goals.

vii. Similar outcomes can be achieved through a lesser restrictive/intensive service.

viii. There is a lack of parental/caregiver involvement or frequent cancellations.

9. Report is signed by the supervising licensed Psychologist or licensed Behavior Analyst.

E. Semiannual Progress Reports

Submit semiannual progress reports (due January 31 and July 31) for these services, using Division forms:

1. Center Based Employment

2. Employment Support Aide

3. Group Supported Employment

4. Individual Supported Employment

In addition to the minimum requirements for the progress report, include:

a. Performance data that identifies the progress of the member toward achievement of the established objectives

b. A detailed record of each contact including hours of service with the member

c. Detailed information regarding specific employment support activities.

CHAPTER 36 - FIRE SAFETY

REVISION DATE:10/9/2015, 7/3/2015, 10/30/2014
EFFECTIVE DATE: January 15, 1996
INTENDED USER(S): Group Home Qualified Vendor
REFERENCE: A.A.C. R9-33-201; A.A.C. R9-33-202

FORM: Fire Risk Profile (DD-254)

Fire Risk Profile

A Fire Risk Profile (FRP) shall be completed for each group home setting serving four or more members. The FRP is a Division instrument that yields a score for a facility based on the ability of members to evacuate the group home. The Fire Risk Profile shall be updated when a member enters or exits the residential program and when the needs of a member, in one or more of the seven categories outlined below, changes significantly. The FRP shall also be updated each time there is a structural change in the home. The FRP is required to be updated at least annually even if changes do not occur in the composition or structure of the setting. A copy of the FRP shall be maintained in each residential setting and must be made available upon request. The FRP will be routinely reviewed by the Division through program monitoring; if concerns are identified, the issue will be referred to Network and/or the Arizona Department of Health Services for resolution.

Instructions for Completing the Fire Risk Profile

The name of each member shall be listed in the designated section of the Fire Risk Profile (FRP). Each member shall be evaluated on the seven (7) factors identified on the FRP, using the rating that best describes the member. Place the appropriate rating values in columns to the right. Add the values for each member to determine the sum of their rating. If a member's rating exceeds 100, use only 100. To determine the facility rating, add together the ratings of all members.

The following guidelines shall be used in evaluating each member's abilities and needs for the seven factors on the FRP:

A. Social Adaptation - This factor rates the member's willingness to assist others and to cooperate in the evacuation process.

1. Positive - the member is generally willing to assist others as far as they are able and can participate in a "buddy system" - helping or alerting anyone close to them in a fire emergency that needs assistance to evacuate. The member's physical ability to help shall not be considered for this item because it will be addressed under other factors. (Rating of 0)

2. None - the member does not usually interact with others in everyday situations and, therefore, could not be expected to assist or alert others in a fire emergency. (Rating of 8)

3. Negative - the member does not interact well with others and exhibits frequent disruptive behavior. They are likely to be uncooperative. (Rating of 16)

B. Mobility Locomotion- This factor rates the member's physical ability to initiate and complete an evacuation.

1. Within Normal Range - the member is physically able to initiate and complete an evacuation. (Rating of 0)

2. Speed Impairment/Needs Some Assistance - the member may require some initial staff assistance, e.g., getting out of bed, getting into a wheelchair, but can continue an evacuation without further assistance and within the three (3) minute timeframe. (Rating of 50)

3. Needs Full Assistance - the member may require the full attention/assistance of a staff throughout the evacuation. (Rating of 100)

C. Response to Instruction - This factor concerns the extent to which a member can receive, comprehend and follow through with simple instructions from staff. Evaluate the amount of guidance required to be reasonably certain that members will follow through with instructions given during an evacuation. Consider only the member's abilities to follow instructions; behavior under stress and sensory impairment are rated as separate factors.

1. Follows Verbal Instructions - the member reliably comprehends, remembers and follows simple, brief instructions stated verbally or in sign language. (Rating of 0)

2. Needs Physical Guidance - the member does not always understand and follow directions; therefore, the member may need to be guided, reminded, reassured or otherwise accompanied during the evacuation, but will not require the exclusive attention of a staff. (Rating of 12)

3. Does Not Respond to Instructions - the member does not respond to instructions or general guidance. The member may require considerable assistance and most of the attention of a staff during the evacuation. (Rating of 24)

D. Behavior Under Stress - This factor concerns the member's ability to cope with stress in an emergency.

1. No Significant Change - the member will probably experience a level of stress that will not markedly interfere with their ability to evacuate. (Rating of 0)

2. Delayed Reaction - the member may react to a fire emergency with confusion, slowed reaction, poor adaptability to hazards or demonstrates a moderate risk for seizure activity that disables the member for no more than 30 seconds. (Rating of 8)

3. Significant Risk - the member may react to a fire emergency with physical resistance, unresponsiveness to evacuation or demonstrates a high risk for seizure activity that disables the member for longer than 30 seconds. (Rating of 16)

E. Fire Awareness - This factor concerns the member's ability to appropriately respond to fire related cues. Fire related cues include smoke, flames, fire alarms, and warnings from others. Evaluate how well the member is likely to perform in response to such cues, assuming that no one may be available to give them instructions at the time of the emergency.

1. Will Evacuate When Signal is Present - the member will probably initiate and complete an evacuation in response to signs of an actual fire, warnings from others or a fire alarm. Also, the member will probably avoid the hazards of a real fire such as flames and heavy smoke. (Rating of 0)

2. Responds to Signals - Needs Assistance to Avoid Hazard - the member will probably respond to an actual fire, warnings from others or a fire alarm; however, the member may not satisfactorily avoid the hazards of a fire or probably cannot complete the evacuation without assistance. (Rating of 8)

3. No Fire Awareness -Needs Assistance - the member does not respond to signs of an actual fire, warnings of others; or a fire alarm. The member should be closely attended by staff during an emergency evacuation. (Rating of 16)

F. Hearing/Sight Impairment - This factor evaluates any sensory impairment which, without adaptations, limits the member's ability to evacuate.

1. Within Normal Limits/Impairmant Doesn't Impact Evacuation - the member may have a severe hearing or sight loss but requires no assistance in case of fire evacuation. Consider special features in the home such as a strobe light or bed vibrator alerting systems. When special features are in the home, a member may be able to evacuate without assistance. (Rating of 0)

2. Impairment Assistance Needed to Start Evacuation - the member has severe hearing and/or sight loss and needs to be alerted to the presence of the fire emergency, but otherwise could evacuate without assistance. (Rating of 10)

3. Impairment Assistance Needed Throughout Evacuation - the member has severe hearing and/or sight loss and needs guidance or other assistance in order to evacuate. (Rating of 20)

G. Medication - This factor evaluates the impact of any medication on a member's ability to evacuate.

1. None - the member does not take medication which can affect their ability to evacuate. (Rating of 0)

2. Maintenance Medication - the member routinely takes medications which can have some effect on the central nervous system, e.g., seizure controlling, antihistamines, mild tranquilizers, stimulants. The primary purpose of these medications is not to induce sleep. The member may need some assistance to evacuate. (Rating of 4)

3. Medication For Sleep - the member routinely takes medication for the primary purpose of inducing or maintaining sleep. (Rating of 8)

Fire Safety Requirements

All group home settings must comply with Level I requirements. Settings with an FRP which exceeds 300 must also comply with Level II requirements.

Level I Fire Safety Requirements

At a minimum, all group home settings shall meet the following:

A. The facility's street address is painted or posted against a contrasting background so that the group home's address is visible from the street; and if posting is not possible, local emergency services have been notified of the location of the home on at least an annual basis.

B. Smoke detectors are working and audible at a level of 75db from the location of each bed used by a resident in the facility and/or capable of alerting all residents in the facility, including a resident with a mobility or sensory impairment. Smoke detectors are located in at least the following areas:

   1. Each bedroom;

   2. Each room or hallway adjacent to a bedroom, except a bathroom or a laundry room; and,

   3. Each room or hallway adjacent to the kitchen, except a bathroom, a pantry, or a laundry room.

C. A minimum of one working, portable, all-purpose fire extinguisher labeled as rated 2A-10-BC by Underwriters Laboratories, or two collocated working, portable, all-purpose fire extinguishers labeled as rated at least 1A-10-BC by Underwriters Laboratories installed and maintained in the facility as prescribed by the manufacturer or the fire authority having jurisdiction.

   1. The provider shall ensure that a fire extinguisher is either disposable and has a charge indicator showing green or 'ready' status; or has been serviced annually by a fire extinguisher technician certified by the National Fire Protection Agency, the International Code Council, or Compliance Services and Assessments.

   2. If serviced and tagged, the documentation must include date of purchase or the date of recharging, whichever is more recent and the name of the company or organization performing the service, if applicable.

D. All stairways, hallways, walkways and other routes of evacuation are free from obstacles that prohibit exit in case of emergency.

E. Each sleeping room has at least one operable window or door that opens onto a street, alley, yard or exit court for emergency exit.

F. Locks, bars, grilles, grates or similar devices, installed on windows or doors which are used for emergency exit, are equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort.

G. A floor plan of the setting is available which designates the routes of evacuation, location of firefighting equipment and location of evacuation devices.

H. The setting has a working non-cellular telephone that is available and accessible to staff and each resident at all times.

I. Emergency telephone numbers for fire, police and local emergency medical personnel, or 911, as appropriate for the local community, and the address and telephone number of the group home are posted near all telephones in the setting.

J. Electrical outlet plates are in good condition and cover the receptacle box.

K. Combustible and/or flammable materials are not stored within three feet of furnaces, heaters or water heaters.

L. As applicable, each operable fireplace in the setting is protected at all times by a fire screen or metal curtain.

M. The premises do not have an accumulation of litter, rubbish, or garbage that may be considered a fire hazard.

Level II Fire Safety Requirements

At a minimum, all group home settings with a Fire Risk Profile (FRP) which exceeds 300 shall meet the following:

A. The setting is in full compliance with the Level I Fire Safety Standards.

B. The setting is equipped with back-up lighting designed to illuminate a path to safety in case of power failure (independent of in-house electrical power) and that this system is inspected at least annually by the manufacturer or an entity that installs or repairs emergency lighting systems.

C. The group home setting has one of the following:

1. Sufficient staff on duty to evacuate all residents present at the facility within three minutes; or,

2. An automatic sprinkler system installed according to the applicable standard by reference in A.A.C. R9-1-412 and installed according to NFPA 13, 13R, or 13D and that covers every room in the entire facility. The automatic sprinkler system is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs automatic sprinkler systems.

D. The group home setting is equipped with an early warning fire detection system that:

1. Is safety approved.

2. Shall either be hard wired or connected wirelessly, with battery back-up, and shall sound every alarm in the setting when smoke is detected.

3. Is installed in each bedroom, each room, or each hallway adjacent to a bedroom, and each room or each hallway adjacent to a kitchen.

4. Is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs early warning fire detection systems.

Fire Inspection

At the time of initial or renewal licensure, the group home settings are directed to pass a fire inspection by state or local fire authorities, or an entity authorized by the Department. Any repair or correction stated in a fire inspection report is made or corrected according to the requirements and time in the fire inspection report.

The fire inspection report should document the setting's full compliance with Level I and, as applicable, Level II Fire Safety Requirements. Documentation of the current completed fire inspection report should be maintained in the group home.

Fire Drill Requirements

A. An evacuation drill including all residents is conducted at least once every six months on each shift; and,

B. Documentation of an evacuation drill is available for review at the facility for at least two years that includes the date and time, duration (should be completed within three minutes) and a summary of the evacuation drill.

C. If a member of the group home setting has been identified as having a condition that could cause harm if the member participated in an evacuation drill, then:

1. The risk shall be identified in the member's ISP and will be reviewed annually.

2. The provider will not include the member in the drill and will simulate evacuation of the member.

3. When this condition is identified, the simulation drill may be increased to five minutes.

CHAPTER 37 THERAPY SERVICES (OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE)

REVISION DATE: 12/27/2023, 5/24/2023, 6/29/2022
REVIEW DATE:
EFFECTIVE DATE: August 1, 2014
REFERENCES: 42 U.S.C. § 1396b (r); 42 U.S.C. § 1396d (a); 42 C.F.R. § 409.43-409.44; 42 C.F.R. § 440.70; 45 C.F.R. § 160.102-103; 45 C.F.R. § 162; A.R.S. § 12-2297; A.R.S. Title 32 Chapter 19; A.R.S. Title 32 Chapter 34; A.R.S. §§ 35-214 and 35-215; A.R.S. § 36-551; A.R.S. Title 36 Chapter 17; A.A.C. Title 4, Chapter 24; A.A.C. Title 4 Chapter 43; A.A.C. Title 9, Chapter 16; A.A.C. R6-6-101; A.A.C. R6-6-2101; A.A.C. R9-22-212; A.A.C. R9-28-101; A.A.C. R9-28-201; A.A.C. R9-28-202; ACOM 414; AMPM 310-X; AMPM 430

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Medically Necessary therapy services to Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Certified Plan of Care" or "CPOC" means a Plan of Care that is signed and dated by the Member's primary care physician (PCP) that becomes the order or prescription for therapy services.
2. "Caregiver" means, for the purposes of this policy, an adult who is providing for the physical, emotional, and social needs of a child or adult with a developmental disability. Examples of Caregivers can include birth parent(s), foster parent(s), adoptive

parent(s), kin or relative(s), group home staff. Caregivers can be licensed, unlicensed, paid, or unpaid.

3. "Co-treatment" means at least two different therapy disciplines delivering therapy to the same Member simultaneously during the same therapy session by licensed therapists.
4. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or

ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Functional Maintenance Program" means the activities established by a therapist to assist the Member in maintaining the progress made during therapy services, or upon discontinuing therapy services when the condition of the Member is evaluated as insignificant or at a plateau.
6. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services (CMS) that are applied to claims to reduce improper coding and thus reduce improper payments of claims.
7. "Medically Necessary" means a service given by a doctor, or licensed health practitioner that helps with a health problem, stops disease, disability, or extends life.

8. "Member" means the same as "client" as defined in A.R.S. § 36-551.
9. "National Provider Identifier Standard" or "NPI" means a standard, unique 10-digit numerical identifier mandated for healthcare providers as defined in 45 CFR § 160.103 for administrative and financial transactions.
10. "Occupational Therapy" means the diagnosis and treatment of disorders concerned with fine motor sensorimotor including sensory processing/sensory integration, feeding,reflexes/muscle tone, functional living skills including socio-emotional developmental needs; and equipment including training, adaptation and/or modification.
11. "Oral Motor/Swallowing/Feeding Disorders" means impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based that may or may not result in deficits of speech production) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow.

12. "Physical Therapy" means diagnosis and treatment of gross motor disorders, gait, balance, proprioception, strength, fine motor, muscle tone, neuromuscular, cardiovascular, reflex testing as appropriate, and equipment including training, adaptation, and/or modifications.
13. "Plan of Care" or "POC" means a written statement developed by a qualified provider and certified by the primary care provider or physician outlining a specific course of treatment for a Member. The Plan of Care includes the Member's treatment diagnosis, assessment results, long-term treatment goals as well as the type, duration, and frequency of therapy or home health nursing services and discharge criteria, education and training components, according to the Member's needs.
14. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

15. "Prior Authorization" means the process by which the DDD or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost-effectiveness, compliance with the Arizona Administrative Code, and any applicable contract provisions. Prior authorization is not a guarantee of payment.
16. "Procedure Daily Maximum Units" means the maximum units of service that a provider is allowed to claim, per CMS, under most circumstances for a Member on a single date of service.
17. "Progress Report" means a record of the Member's treatment and response to treatment written by the treating therapist at intervals stipulated by the Division that typically states the number of sessions and attendance, services provided, objective measures of progress toward goals, justification of medical necessity for treatment, and changes to the goals or Plan of Care, as appropriate.

18. "Qualified Vendor" or "contractor" for the purposes of this policy means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
19. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.
20. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.
21. "Service Authorization Request" means a request by the Member/Health Care Decision Maker, and Designated Representative (DR) or a provider for a physical or behavioral

health service for the Member which requires Prior Authorization (PA) by the Contractor.

22. "Speech-Language Pathology" or "Speech Therapy" means the diagnosis and treatment of communication, cognition, and swallowing disorders. The scope of practice includes, but is not limited to, disorders of speech fluency, production, resonance, voice, language, feeding, hearing, and swallowing for Members of all ages. Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing.
23. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for Arizona Health Care Cost Containment System (AHCCCS) benefits.
24. "Treatment Note" means a record of a therapy treatment session documented by the treating therapist that demonstrates the treatment provided, the Member's progress toward goals, and the need for therapy services.

POLICY

A. PROVIDER REQUIREMENTS AND QUALIFICATIONS

1. Vendors shall have an active Qualified Vendor Agreement with the Division to provide Physical Therapy, Speech Therapy, and Occupational Therapy services to Division Members.
2. Qualified Vendors shall comply with all applicable service requirements, service specifications, standard terms and conditions, and all other provisions of the Qualified Vendor Agreement.
3. Qualified Vendors shall ensure the following therapy providers are licensed or provide services under the supervision of a licensed therapist of the same discipline within their scope of practice:
    a. Physical therapists;
    b. Physical Therapy assistants;
    c. Speech-Language Pathologists;
    d. Speech-Language Pathology assistants;
    e. Occupational therapists; and
    f. Occupational Therapy assistants.

B. ESTABLISHING THERAPY SERVICES

1. Qualified vendors shall obtain prior authorization from the Division before providing the following therapy services to Members:
    a. Speech Therapy evaluation;
    b. Occupational Therapy evaluation;
    c. Physical Therapy evaluation;
    d. Feeding or swallowing evaluation;
    e. Speech Therapy sessions;
    f. Physical Therapy sessions;
    g. Occupational Therapy sessions; and
    h. Feeding or swallowing therapy sessions.
2. Qualified Vendors shall ensure therapy services are Medically Necessary based on the supporting documentation of medical need and the appropriateness of the equipment, service, or supply prescribed by the physician or other licensed practitioner of the healing arts.
3. Qualified Vendors shall ensure the amount, frequency, and duration of therapy services are always commensurate with the

Member's medical and therapy needs, level of disability, and standards of practice.

4. Qualified Vendors shall require the following documentation prior to providing therapy services to Members:
   a. An order or prescription from the Member's Primary Care Provider (PCP) with the following information:
      i. The type of therapy requested;
      ii. "Evaluation and treatment as recommended by therapy clinician";
      iii. PCP's signature dated less than one year ago; and
      iv. PCP's NPI number.
   b. A service authorization for therapy evaluation from the Member's Support Coordinator.

C. INITIAL EVALUATION AND PLAN OF CARE

1. Upon meeting the criteria in (B) of this policy, Qualified Vendors who provide therapy services shall evaluate the Member's skills and develop a Plan of Care (POC) to substantiate a recommendation for Medically Necessary therapy services.

2. If a Member requires more than one visit to complete a therapy evaluation, the Qualified Vendor providing therapy services shall complete the following prior to the next evaluation visit:
    a. Provide the Support Coordinator justification in writing;
    b. Request a service authorization from the Support Coordinator; and
    c. Attend a peer-to-peer consultation with requesting Division staff to determine appropriateness in certain cases.
3. Based on the Member's evaluation results, the Qualified Vendor providing therapy services shall include the following information in the POC:
    a. Member's date of birth and age;
    b. Member's medical history and background;
    c. History of prior therapy and referrals as applicable;
    d. Diagnoses;
    e. Date of evaluation;
    f. Baseline objective measurements based on standardized testing, performed or other standard assessment tools;
    g. Type of therapy service;

h. Short term and long term treatment goals for the entire episode of care;

i. Goal baselines and timelines;

j. Proposed type of service or interventions;

k. Home program goals;

l. Session start and stop time;

m. Frequency of therapy services;

n. Member's primary language;

o. Prognosis for improvement;

p. Safety risks;

q. Adaptive equipment or assistive devices, as applicable;

r. Criteria for discontinuing therapy services;

s. Date the POC was established;

t. Requested dates of service for planned treatments after the completion of the evaluation;

u. Responsible Person's expected involvement in the Member's treatment; and

v. Signature, date, and credentials of the therapist who developed the POC.

4. The Qualified Vendor that evaluated the Member for therapy services may use any of the following to document the Member's therapy evaluation and POC:
    a. The DDD-2088A Evaluation Report Plan of Care/Treatment Plan: Certification/Recertification form;
    b. The Qualified Vendor's own clinical form; or
    c. The Qualified Vendor's Electronic Medical System (EMR).

D. CERTIFICATION OF THE POC FOR AUTHORIZATION OF THERAPY SERVICES

1. The Qualified Vendor that evaluated the Member for therapy service shall submit the POC to the PCP that originally ordered or prescribed the therapy evaluation and treatment to request certification of the POC and to initiate therapy services if the therapy evaluation results substantiate a recommendation for Medically Necessary therapy service.
2. The Qualified Vendor shall ensure the Certified Plan of Care (CPOC) contains the following information from the PCP that originally prescribed the therapy evaluation and treatment for the Member:

a. The PCP's dated signature; and

b. The PCP's National Provider Identification (NPI) number.

3. Upon receipt of the CPOC from the Member's PCP, the Qualified Vendor shall submit the following to the Member's Support Coordinator:

a. A copy of the CPOC within 21 calendar days to request a service authorization for therapy services; and

b. A statement of whether or not the Member has Third Party Liability (TPL); and

c. If the Member has TPL, information on the Member's TPL coverage.

4. The Qualified Vendor shall not ask the Member's PCP to attest to agreeing with the POC prior to the date the POC is reviewed.

E. DELIVERY OF THERAPY SERVICES

1. Qualified Vendors shall not provide therapy services without a service authorization from the Support Coordinator.

2. The Qualified Vendor shall ensure therapy services provided are consistent with the Member's CPOC rather than primarily for the

convenience of the Member, Responsible Person, or therapy provider.

3. The Qualified Vendor providing therapy services may allow the Member to make up missed therapy sessions during the service authorization period within 30-calendar days as long as:
   a. The total number of sessions or units delivered does not exceed the amount authorized;
   b. The make-up session occurs on a separate and distinguished date;
   c. Medicaid National Correct Coding Initiative Edits and Procedure Daily Maximum Units are followed; and
   d. The CPOC permits make-up sessions.
4. The Qualified Vendor shall refer to the DDD Qualified Vendor Rate Book for more information about the modifiers specific to the missed therapy sessions and make-up therapy sessions.
5. The Qualified Vendor providing therapy services shall develop a Functional Maintenance Program for Members and their Caregivers to implement therapeutic activities as part of the Member's daily routine.

6. The Qualified Vendor providing therapy services shall review and update the Member's Functional Maintenance Program as part of all therapy sessions.

F. RESPONSIBLE PERSON/CAREGIVER PARTICIPATION

1. The Qualified Vendor providing therapy service shall require the attendance and active participation of the following individuals in the Member's therapy sessions to maximize the benefit of the service, improve outcomes, and carry out the Functional Maintenance Program:
   a. Responsible Person if other than the Member;
   b. Caregiver(s);
   c. Family member; or
   d. Other individual(s) designated by the Planning Team if the Member does not have a Responsible Person, Caregiver, or family member available.
2. The Qualified Vendor providing therapy service shall ensure the Responsible Person informs all other Caregivers regarding the therapeutic activities that comprise the Member's therapy program.

3. If the Responsible Person does not attend the therapy session the Qualified Vendor providing therapy service shall,:
    a. Cancel the therapy session;
    b. Notify the Member's Support Coordinator of the lack of participation of the Responsible Person prior to the next therapy session; and
    c. Document the reason for the cancellation of the therapy session on the quarterly Progress Report.
4. If the Qualified Vendor providing therapy service recommends that the Responsible Person or Caregiver observes the therapy session outside the eyesight of the Member, the therapist shall submit this recommendation to the Support Coordinator via the evaluation and CPOC before this type of participation is used.

G. UPDATE TO THE POC, RECERTIFICATION, AND REEVALUATION

1. The Qualified Vendor providing therapy service shall, if the Member requires Medically Necessary therapy past the service authorization end date, complete the following 30 days in advance of the service authorization end date to avoid gaps in service:

a. Provide the Member's PCP with an updated POC for recertification; and

b. Submit the updated CPOC to Member's Support Coordinator via the Division's FTP site for reauthorization of service.

2. The Qualified Vendor providing therapy service shall include the following information on the updated POC when requesting recertification of services:

a. A progress summary;

b. Date therapy services started;

c. Dates of therapy services requested;

d. Changes in the POC and rationale;

e. Requested change in frequency of visits for changing the plan, if applicable;

f. Documentation of reasons continued therapy services are Medically Necessary;

g. Documentation of Member's and Responsible Person's participation in treatment or adherence to a Functional Maintenance program;

h. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable;

i. Adaptive equipment or assistive devices, as applicable;

j. Prognosis with clearly established criteria for discontinuing therapy service;

k. Documentation of consults with other professionals and services or referrals made and coordination of service when applicable;

l. The updated POC shall be signed and dated by the therapist responsible for the therapy services;

m. The updated POC shall be signed and dated by the ordering provider; and

n. For recertifications of therapies, if the submitted request is not signed and dated by the ordering provider, the request is accompanied by a valid written order or prescription.

3. The Qualified Vendor providing therapy services shall reevaluate the Member at least every three years, or if any of the following apply:

a. The Member's Support Coordinator identifies a limitation in a functional area.

b. The Member's PCP or other licensed healthcare professional identifies a limitation in a functional area.

c. The Member's Caregiver or Responsible Person identifies a limitation in a functional area.

d. The Member presents with a change in medical status that is not rehabilitative.

e. There is a change in Qualified Vendor and the Member has not had an evaluation within the last year.

f. The Member is undergoing redetermination for eligibility.

4. The Qualified Vendor providing therapy service shall update the POC, obtain recertification of the POC from the PCP, and request reauthorization of therapy services from the Support Coordinator as per G.1 and G.2 of this policy upon completing the reevaluation if Medically Necessary therapy services are required.

5. The Qualified Vendor providing therapy service shall discontinue therapy services as per the requirements in J. of this policy if the Qualified Vendor determines that the Member does not require Medically Necessary therapy services.

H. DAILY TREATMENT NOTES AND PROGRESS REPORTING REQUIREMENTS

1. The Qualified Vendor providing therapy service shall complete a daily Treatment Note for every therapy session with the Member with the following information:
   a. Events of a session;
   b. Member interactions;
   c. The type of therapy;
   d. Any accommodations and modifications to clinical procedures;
   e. The treating therapy provider or supervisor’s signature and credentials; and
   f. Responsible Person’s signature.
2. The Qualified Vendor providing therapy service shall document reasons for visits outside the weekly or monthly frequency

indicated in the CPOC in the Member's daily Treatment Note and quarterly Progress Reports.

3. The Qualified Vendor providing therapy service shall submit a Progress Report to the Division's FTP site at least once every 90 days (quarterly) or by the end of the certification timeframe if the CPOC is less than 90 days.
4. The Qualified Vendor providing therapy service shall submit quarterly Progress Reports to the Division with the required information as outlined in Chapter 35 Progress Reporting Requirement of the DDD Provider Manual.
5. The Qualified Vendor providing therapy service may use the DDD-2063A Ongoing Quarterly Progress Report (QPR) Plan of Care/Treatment Plan: Certification/Recertification form or may opt to use their own clinical form or EMR for submitting quarterly Progress Reports or for recertification of the POC.
6. The Qualified Vendor providing therapy service may use the fourth quarterly Progress Report for updating the POC and submitting the POC to the PCP for recertification.

7. The Qualified Vendor providing therapy service shall document the beginning of the first reporting period as the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, reevaluation, or treatment.
8. The Qualified Vendor providing therapy service shall retain the Member's Progress Reports, Treatment Notes, and all other therapy documentation in accordance with A.R.S. § 12-2297.

I. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The Qualified Vendor shall refer to Chapter 6 of the DDD Provider Manual for information on EPSDT covered services that apply to individuals under the age of 21 who need therapy services.

J. DISCONTINUATION OF SERVICES

1. The Qualified Vendor providing therapy service shall not discontinue the Member's therapy services without agreement from the Planning Team.
2. The Qualified Vendor providing therapy service and Planning Team shall discontinue the Member's treatment when any of the following occur:

a. The disorder(s) resulting in therapy services is remediated;

b. Environmental or behavioral modifications strategies are successfully established;

c. The Responsible Person chooses not to participate in treatment;

d. The Member chooses not to participate in treatment;

e. The Member's attendance to therapy is inconsistent or poor and efforts to address these factors are unsuccessful;

e. The Member moves to another location where therapy services from the current therapy provider are not available;

f. The Member or Responsible Person chooses to seek a different therapy provider.

3. The Qualified Vendor providing therapy services shall advise the Planning Team, Member, and Responsible Person if other than the Member of the likely outcomes should discontinuation of therapy services occur.

4. If the Planning Team does not mutually agree upon the Qualified Vendor's request for release, the Qualified Vendor may submit a

request for release from service authorization to the DDD Customer Service Center as outlined in the Provider Manual, Chapter 50, Section II.G.

5. The Qualified Vendor providing therapy services shall:
   a. Review and analyze the treatment provided to the Member by the treating therapist to identify specific modification(s) that have the greatest probability of yielding improved outcomes; and
   b. Based on (a) implement those improvements with ongoing monitoring when considering discontinuing therapy treatment in situations other than those described in this section.
6. The Qualified Vendor providing therapy services shall document in the Member's final Progress Report that the following factors have been addressed before discontinuation of therapy:
   a. Intervention goals and objectives were specified;
   b. Instructional time was provided;

c. Current and suitable intervention methods or materials were used;

d. Functional performance data were collected and analyzed on an ongoing basis to monitor and evaluate progress;

e. Assistive technology or other technology supports were provided when necessary;

f. A plan to address the needs and concerns of culturally or linguistically diverse members and families (e.g., use of interpreter or translator) has been addressed if necessary;

g. Relevant and accurate criteria were used to evaluate the intervention; and

h. Health, educational, environmental, or other supports relevant to communication interventions were provided.

7. The Qualified Vendor providing therapy service shall refer the Member to professionals with specific expertise in the area of concern prior to discontinuing therapy service if any of the following situations occur:

a. The provision of treatment is beyond the expertise of the individual therapist.

b. The therapist's recommendations are not acceptable to the Responsible Person.

c. Treatment no longer results in measurable benefits and any reasonable prognosis for improvement with continued treatment is not evident. Reevaluation should be considered at a later date to determine whether the Member's status has changed or whether new treatment options have become available.

d. The Member is unable to tolerate the treatment because of a serious medical, psychological, or other condition.

e. The Member demonstrates behavior that interferes with improvement or participation in treatment providing those efforts to address the interfering behavior has been unsuccessful.

8. Upon discontinuing therapy services, the Qualified Vendor shall complete and submit via the Division's FTP site to the Support Coordinator a final Progress Report that includes the following:

a. All treatment provided since the last Progress Report to the date therapy services were discontinued;

b. A statement indicating the therapist reviewed all Treatment Notes; and

c. A statement indicating the therapist agrees to discontinue services.

K. FUNCTIONAL MAINTENANCE PROGRAM UPON DISCONTINUING THERAPY SERVICES

1. The Qualified Vendor shall formulate and implement a Functional Maintenance Program for the Member upon discontinuing therapy services to maintain therapeutic gains.
2. The Qualified Vendor shall, upon discontinuing therapy service, instruct the Responsible Person, family member, or Caregiver as appropriate in the established Functional Maintenance Program components.

3. After a Functional Maintenance Program is implemented, the Qualified Vendor shall not bill for services, except for prior authorized reassessments and POC revisions.
4. The Qualified Vendor providing therapy service shall reassess and revise the Member's Functional Maintenance Program as needed.

L. CO-TREATMENT

1. The Qualified Vendor providing therapy services shall include Co-treatment in the CPOC when it is Medically Necessary for the Member to receive therapy from two different therapy disciplines simultaneously.
2. When performing Co-treatment, the two performing therapists shall designate a primary therapist.
3. The Qualified Vendor shall maintain the following Co-treatment documentation requirements in the Member's medical records as follows:
    a. Medical necessity for the individual therapy services before performing Co-treatment;

b. Co-treatment goals and how Co-treatment will help the therapist achieve the therapist's goals for the Member, for each therapy discipline; and

c. Justification of the Member's need to receive Co-treatment.

4. The Qualified Vendor shall cooperate with requests from the Division for retrospective review of the Member's therapy records.

M. BILLING

The Qualified Vendor providing therapy services shall refer to Provider Manual Chapter 12, Billing and Claim Submission for requirements for submitting therapy service claims.

CHAPTER 38 – EMERGENCY COMMUNICATION WHEN TRANSPORTING A MEMBER

EFFECTIVE DATE: Effective upon signature of Amendment #1 RFQVA 710000

For the health and safety of each member, the Qualified Vendor shall ensure that all methods of transportation allow for emergency communication at any time during the delivery of the service. The method of emergency communication shall be appropriate to the geographic area (e.g., two-way radio, a cellular phone, or satellite based communication system).

40 INSURANCE REQUIREMENTS FOR QUALIFIED VENDORS

REVISION DATE: 2/28/2024
REVIEW DATE: 5/5/2023
EFFECTIVE DATE: November 10, 2016
REFERENCES: RFQVA DDD-2024

PURPOSE

The purpose of this policy is to outline the Division's general insurance and Sexual Abuse and Molestation (SAM) coverage requirements for Qualified Vendors.

DEFINITIONS

1. "Qualified Vendor" or "QV" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
2. "Qualified Vendor Agreement" or "QVA" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the

relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.

3. "Sexual Abuse and Molestation Insurance" or "SAM" means liability coverage for claims that may arise related to abusive behaviors committed by the insured and insured's employees.

A. GENERAL INSURANCE REQUIREMENTS

1. The Qualified Vendor shall obtain and maintain current insurance coverage as required by the RFQVA DDD-2024.
2. The Qualified Vendor shall submit all required liability insurance coverage documentation and insurance agent's contact information to the Department's insurance tracking and monitoring system portal.

B. ADDITIONAL SEXUAL ABUSE AND MOLESTATION (SAM) INSURANCE REQUIREMENTS FOR QUALIFIED VENDORS PROVIDING THERAPY SERVICES

1. Qualified Vendors that provide occupational, physical therapy, or speech therapy services to Members shall document the name and relationship of the paid or unpaid caregiver present with the

Member during each evaluation or therapy session, including telehealth sessions.

2. Qualified Vendors that provide occupational, physical therapy, or speech therapy services to Members without a caregiver present shall carry SAM insurance coverage as required in the RFQVA DDD-2024 in the section titled, "For All Other Qualified Vendors".

CHAPTER 41 – TERMINATION OF THE QUALIFIED VENDOR AGREEMENT UPON REQUEST OF THE QUALIFIED VENDOR

REVISION DATE: 3/25/2016

EFFECTIVE DATE: April 1, 2015

INTENDED USER(S): Business Operations staff (Contract Unit and Fiscal Integrity), Network staff, Quality Assurance staff, Support Coordination, Qualified Vendors

REFERENCES: A.A.C. 6-6-2100 et. seq., A.R.S. §36-2904.G, Division Provider Manual Chapter 34 Provider Publications

Section Six of the Qualified Vendor Agreement (Agreement) requires the following will be completed when a Qualified Vendor requests termination of its Agreement:

The Qualified Vendor shall:

A. Provide a 60 day written notice to the Division's Contract Management Unit setting forth the reasons for requesting termination.

B. Submit a draft of the written notice for members/families and subcontractors, if applicable, regarding the termination to the District's Network Manager/designee for review and approval. The written notification must:

   1. Be written in 6th grade or below reading level, as specified in Chapter 34 of the Division's Provider Manual; and,

   2. Include assurance that the Qualified Vendor will assist with transitioning members to alternate providers.

C. Mail approved letter to members/families and subcontractors, if applicable, upon receipt approval of draft letter from the Network Manager/designee and of termination acceptance notification from the Contract Manager/designee.

D. Continue to perform in accordance with the requirements of the Agreement up to or beyond the date of termination as directed in the termination acceptance notice provided by the Contract Manager/designee.

E. Make provisions for continuing all management/administrative services until the transition of members is completed and all other requirements of the Agreement are satisfied.

F. Facilitate any medically-necessary appointments for care and services for members.

G. Assist in the training of personnel, at the Qualified Vendor's own expense, as required by the Division.

H. Ensure distribution of Client Funds to appropriate parties.

I. Complete and submit copies of all final progress reports and other data elements to the assigned Division Support Coordinator.

J. Pay all outstanding obligations for care rendered to members.

K. Provide the following financial reports to the Division's Business Operations Fiscal Integrity Unit:

1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts;

2. A monthly summary of cash disbursements; and,

3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor's bank accounts.

All reports in this section shall be due on the 15th day of each succeeding month for the prior month.

L. Submit a final claim to the Division for payment, pursuant to A.R.S. §36-2904.G.

M. Upon termination, all goods, materials, documents, data and reports prepared by the Qualified Vendor under the Agreement shall become the property of and be delivered to the State on demand.

N. Retain records as specified in the Agreement.

O. Be liable to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Qualified Vendor.

Division's Business Operations (Contract Management, Claims, and Fiscal Integrity)

A. The Contract Management Unit will provide written notice of acceptance of such termination and the proposed termination date.

1. The notification will be issued by the Contract Management Unit and will include information informing the Qualified Vendor of its responsibility to notify members/families and subcontractors in writing of its intent to terminate the Agreement and outlining the transition process.

2. The Contract Management Unit will send a copy of the termination acceptance notification and the *Transition Roster* to the Division's Network Manager(s). The *Transition Roster* is for all services being provided by the Qualified Vendor and includes:

A list of open authorizations by service, timelines for Division Network notification to members and, timelines for transition of members to alternate providers.

B. The Fiscal Integrity Unit will verify the following financial information from the Qualified Vendor:

1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts.

2. A monthly summary of cash disbursements.

3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor's bank accounts.

4. All reports in this section shall be due on the 15th day of each succeeding month for the prior month.

Division's District (Support Coordination, Network, and Client Funds)

The Division's District will:

A. Review/approve the Qualified Vendor's written notice to members/families and subcontractors, if applicable, of the intent to terminate the Qualified Vendor Agreement.

B. The Network Manger or designee will notify members in writing of the network change as outlined in the *Transition Roster*.

C. Attend transition meetings with the Qualified Vendor to ensure the smooth transition of members to alternate providers.

D. Update the *Transition Roster* and track the authorizations for each member.

E. Coordinate the transition of authorizations to alternate provider.

F. Ensure all ISP documentation reflects changes.

G. Provide updates on the *Transition Roster* to the Contract Management Unit regarding the transition to its completion.

H. Remove the Qualified Vendor from all Directories.

I. Remove the Qualified Vendor from the Vendor Call Lists.

J. Resolve/close any open issues in the Resolution System, as appropriate.

K. Reconcile all Client Funds for which the Division is Representative Payee.

CHAPTER 42 – ELECTRONIC MONITORING IN PROGRAM SITES

REVISION DATE: 03/22/2023, 05/01/2015
EFFECTIVE DATE: April 1, 2015
REFERENCES: A.R.S. §12-2297, A.R.S. §36-551.01, A.R.S. §36.568

PURPOSE

To distinguish the circumstances under which on-site and~~/or~~ remote electronic monitoring may be conducted in programs and services funded by the Division.

DEFINITIONS

1. "Common Area" means a room, including a hallway that is designed for use by multiple individuals, including residents. Bedrooms, toileting areas, and bathing areas are excluded from this definition, regardless of the number of individuals for which the area is designed.
2. "Electronic Monitoring Device" means the same as defined in A.R.S. § 36-568(E).
3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "Responsible Person" means the same as defined in A.R.S. § 36-551.

POLICY

A. Day Program and Employment Services

1. Prior to installing or using Electronic Monitoring ~~equipment~~ Devices in either a service site or a vehicle used for transportation during the provision of services, the Qualified Vendor must notify the Division's

Provider Network Support Unit at providernetworksupport@azdes.gov and provide a copy of the policy~~,~~ procedures, and notices for approval.

2. The Qualified Vendor shall only use Electronic Device in Common Areas of the service site.

3. The Qualified Vendor shall post a ~~A~~ sign ~~must be posted~~ in a conspicuous place in each Common Area and vehicle that is under surveillance which indicates the days and hours of surveillance.

4. The Qualified Vendor shall:

   a. Ensure records created by Electronic Monitoring Devices are maintained in accordance with A.R.S. §12.2297.

   b. Produce records upon request of a Responsible Person, the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law.

B. Group Homes and Nursing Supported Group Homes

1. Qualified Vendors of Group Homes, or Nursing Supported Group Homes may only install, oversee, and monitor Electronic Monitoring Devices in Common Areas of the home and then only If written agreement is received from each Responsible Person for Members who live in the home:

   i. To install the Electronic Monitoring Devices in Common Areas, and

ii. To release HIPAA protected information in the form of live stream and recorded information from the Electronic Monitoring Devices to all Responsible Parties for Members who live in the home .

2. The Qualified Vendor may contract with a third party to install, oversee, and monitor Electronic Monitoring Devices.
3. The Division shall consider actions under (2) to be overseen and monitored by the Qualified Vendor for the purposes of this policy.
4. A Qualified Vendor may allow Responsible Persons of Members who live in the home to share in the cost of the installation, oversight, and monitoring of Electronic Monitoring maintained by the Qualified Vendor if the Responsible Party agrees to the arrangement.
5. If all Responsible Persons for Members who live in the home agree, a Qualified Vendor must permit installation of Electronic Monitoring Devices in Common Areas of the setting at the expense of the Responsible Persons.
    a. The Qualified Vendor is not responsible for the installation, maintenance, or monitoring of the Electronic Monitoring Device installed at the expense of the Responsible Persons.

b. The Qualified Vendor may not access the live stream or recordings generated at the expense of the Responsible Persons without the written permission of all Responsible Persons for Members who live in the home.

c. For Electronic Monitoring Device installed at the expense of the Responsible Persons the Qualified Vendor shall not:

i. Turn off or on the Electronic Monitoring Device.

ii. Cover up or in any way obscure the ability of the Electronic Monitoring Device to have full view of the area chosen by the Responsible Person.

iii. Move the Electronic Monitoring Device.

iv. In any other way assist or hamper the operation of and use of the Electronic Monitoring Device.

6. If, after the installation of an Electronic Monitoring Device, any Responsible Person notifies the Qualified Vendor in writing that they are no longer in agreement with use of Electronic Monitoring Devices in Common Areas of the setting, the Qualified Vendor shall:

a. If the Electronic Monitoring Device is maintained and monitored by the Qualified Vendor :

i. Stop using the Electronic Monitoring Devices;

ii. Notify all Responsible Persons of the discontinuation of Electronic Monitoring in the setting;

iii. Remove the Electronic Monitoring Devices or ensure the Electronic Monitoring Device has clearly been disabled.

b. If the Electronic Monitoring Device is maintained and monitored by the Responsible Persons, notify the Responsible Persons in writing that:

i. Use of the Electronic Monitoring Devices must cease immediately;

ii. The Electronic Monitoring Devices must be removed from the setting by the Responsible Persons; and

iii. Any damage caused by the installation or removal of the Electronic Monitoring Device must be repaired by the Responsible Persons at the time of removal.

7. The Qualified Vendor shall post a clearly legible sign at each entrance to the premises and ensure the sign:

a. Reference A.R.S. § 36-568;

b. States that Electronic Monitoring Devices are in use on the premises;

c. Is clearly visible ; and

d. Is printed with a size and font that is easily readable from a reasonable distance.

8. An Qualified Vendor shall:

a. Comply with Health Insurance Portability and Accountability Act ("HIPAA") and other applicable state and federal law addressing confidentiality; and

b. Specify in policy how Electronic Monitoring Device recordings, regardless of format, will be secured to protect the confidentiality of residents, including:

i. Which personnel may have access to the Electronic Monitoring Device recordings; and

ii. Under what circumstances access to the Electronic Monitoring Device recordings may be allowed.

9. The Qualified Vendor shall retain and have accessible any Electronic Monitoring Device recordings, regardless of format, generated by the Electronic Monitoring Devices installed and monitored by the Qualified Vendor for a minimum of 30 calendar days.

10. The Qualified Vendor shall retain the records longer than 30 calendar days if:

a. Required to do so by a contractual obligation;

b. The Qualified Vendor's policy specifies that the Qualified Vendor maintain the records beyond 30 calendar days;

c. The Qualified Vendor reasonably anticipates legal actions for which the records may be relevant;

d. A court order or other legal process requires the retention of all or some of the records for a longer period of time; or

e. A law or regulation that supersedes this policy requires a longer period of record maintenance.

11. A Qualified Vendor who installs an Electronic Monitoring Device shall:

a. Evaluate all Electronic Monitoring Devices at least quarterly to ensure the Electronic Monitoring Devices are properly functioning, secure from access by unauthorized personnel, and are being used in compliance with this Section.

b. Monitor adherence to policies and promptly address non-compliance.

c. Maintain a log of all monitoring of Electronic Monitoring Devices that includes:

i. The date of the monitoring;

ii. The name of the individual who performed the monitoring;

iii. Any deficiencies identified during the monitoring; and

iv. The method, date, and who remediated any deficiencies.

d. Develop and provide training to all personnel who have access to the record that details:

i. The requirements related to disclosure of the record;

ii. HIPAA and all other applicable laws related to confidentiality and privacy;

iii. The maintenance and operation of the Electronic Monitoring Devices and any associated storage devices;

iv. The methods that shall be used to secure the record;

v. A list of all individuals allowed access to the records

vi. The reporting method to be used in the event of any breach in the security of the record or misuse of the Electronic Monitoring Device; and

vii. All policy related to the installation and use of Electronic Monitoring Devices.

e. Provide the training to all personnel who have access to the record.

i. Prior to the personnel being provided access to the record; and

ii. Annually following the initial training.

f. Develop and implement policies for the Qualified Vendor's personnel that:

i. Address disclosure, confidentiality, maintenance, monitoring, and training provisions of this policy;

ii. Outline training that will be provided to ensure that personnel use Electronic Monitoring Devices appropriately;

iii. Outline the maintenance and distribution of records and

iv. Outline how the Qualified Vendor will ensure quarterly monitoring occurs.

g. Make policies, training records, training acknowledgments, evaluations, and monitoring logs available to the Division as requested..

12. Qualified Vendors shall not interfere with or assist in the use of an Electronic Monitoring Device by a Responsible Person in the private bedroom of a Member including:

a. Turning the device on or off.

b. Covering up or in any way obscuring the ability of the device to have a full view of the area chosen by the Responsible Person.

c. Moving the device.

13. The Responsible Persons shall repair any damage caused by the installation of or removal of any Electronic Monitoring Device installed in the home.

14. The Qualified Vendor shall:

    a. Ensure records created by Electronic Monitoring Devices ~~will be~~ are maintained in accordance with A.R.S. §12.2297.

    b. Produce records upon request of a Responsible Person, the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law.

CHAPTER 43 RESPITE PROVIDED AT CAMP TO DIVISION MEMBERS

REVISION DATES: 11/09/2022, 1/29/2016

EFFECTIVE DATE: April 15, 2015

INTENDED USERS: Qualified Vendors, Support Coordinators, Network Staff, and Business Operations

PURPOSE

The purpose of this policy is to establish requirements for Qualified Vendors when respite services are used for members to attend a Camp.

DEFINITIONS

1. **"**Camp" means a Qualified Vendor service site or Community Setting used to provide respite to a member's primary caregiver while concurrently providing recreational activities for the member. Camp may be daily or overnight.
2. "Community Setting" means a location generally available to the public that is not owned or controlled by a qualified vendor.

POLICY

A. UTILIZATION OF RESPITE FOR CAMP

1. Members assessed and authorized eligible to receive respite may choose to use respite to attend Camp.
2. The Qualified Vendor shall bill for respite beginning when the member is transferred from the primary caregiver or other natural support to the Qualified Vendor.
3. The Qualified Vendor may bill Respite when the member is transported to Camp by the vendor.

B. PROGRAM SITE REQUIREMENTS FOR CAMP

1. The Qualified Vendor shall cooperate with the Division's Office of Licensing, Certification, and Regulation (OLCR) inspection at any site owned or controlled by the Qualified Vendor that is used to provide respite services to Division members. The OLCR shall not inspect Community Settings.
2. The Qualified Vendor shall ensure that:
   a. All direct care staff or volunteers working with Division members meet all training and background requirements as outlined in the Qualified Vendor Agreement and A.A.C. Title 6, Chapter 6, Article 15.

b. Staff-to-member ratios comply with and be billed in accordance with the Division's Qualified Vendor Agreement, Respite Services Specification, and Rate Book.

c. All members attending Camp be included in the calculation of staff-to-member ratios, including non-Division funded individuals.

C. CAMP RELATED ACTIVITY FEES

1. The Qualified Vendor may, if necessary and appropriate for the Camp activities and setting, request activity fees covering food and supplies for special Camp activities, since these costs are not included in the respite rate.
2. The Qualified Vendor shall offer an alternative no-cost activity or provide scholarships for members who cannot or do not want to pay an activity fee.
3. The Qualified Vendor shall not determine program participation based on the ability of a member to pay an activity fee.

46 AGENCY WITH CHOICE

REVISION DATE: 05/10/2023;04/03/2019
EFFECTIVE DATE: April 1, 2015
REFERENCES: Social Security Act; A.A.C. R9-28-509; AMPM 1310-A

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Agency With Choice services for Division Members who are eligible for ALTCS.

DEFINITIONS:

1. "Agency with Choice" or "AWC" means a member-directed service delivery model option offered to Members eligible for ALTCS who reside in their own home in which the provider agency and the Member or Responsible Person enter into a partnership agreement wherein the provider agency serves as the legal employer of the Direct Care Worker and the Member or Responsible Person serves as the day-to-day managing employer of the Direct Care Worker.
2. "Direct Care Worker Agency" means an agency registered with AHCCCS as a service provider of Attendant Care, Personal Care, Homemaker or Habilitation. The agency, by registering with AHCCCS,

warrants that it has a workforce (employees or contractors) with the abilities, skills, expertise, and capacity to perform the services as specified in AHCCCS policy.

3. "Direct Care Worker" means an individual employed by a Direct Care Worker Agency, who assists an individual with a disability with activities necessary to allow them to reside in their home.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Division.
6. "Qualified Vendor Agreement" means a contract that consists of the combination of the Request for Qualified Vendor Agreement, the terms and conditions, the specifications, the schedules, the exhibits, the attachments, and any RFQVA amendments.
7. "Request for Qualified Vendor Agreement" means the application a vendor submits to the Division to become a Qualified Vendor.

POLICY

A. The Qualified Vendor and Member or Responsible Person may agree to opt-in anytime for any or all of the following AWC services:

1. Habilitation;
2. Homemaker;
3. Individually Designed Living-Hourly;
4. Attendant Care;
5. Habilitation Hourly Support.

B. The Qualified Vendor shall refer to Division Provider Policy Manual Appendix A Qualified Vendor Application and Directory System (QVADS) Provider Instructions – Agency with Choice Option for guidance to "Opt-In" as an AWC vendor.

C. Once the Qualified Vendor has opted-in to AWC,the Qualified Vendor may opt-out for any or all AWC services only after closure of authorizations for Members who selected AWC service delivery option.

D. The Qualified Vendor shall refer to the Division Provider Policy Manual Appendix B DDD Agency with Choice User Guide – FOCUS Vendor instructions, for billing as an AWC vendor.

E. The Qualified Vendor shall either acknowledge or deny the service authorization within three business days upon receipt of a new service authorization.

F. Upon acknowledgement of the service authorization, the Qualified Vendor shall use a Healthcare Common Procedure Coding System U-7 modifier when submitting claims to the Division for services provided under the AWC service delivery option.

G. For questions about Opting-In to AWC in QVADS, the Qualified Vendor may call l 844-770-9500.

H. For questions about AWC billing, the qualified vendor may contact DDD-Claims@azdes.gov.

CHAPTER 47 MANAGING VENDOR CALL LISTS, VENDOR DIRECTORIES, SCOPE OF SERVICES AND REPORTING REQUIREMENTS

REVISION DATES: 6/2/21, 8/21/19
EFFECTIVE DATE: April 28, 2017
REFERENCES: A.A.C. R6-6-2103–2106

PURPOSE: This policy addresses the process by which a Qualified Vendor notifies the Division of Developmental Disabilities (Division) of its intent to amend or make changes to its scope of services. This includes the intent to reduce the type of service the Qualified Vendor is willing or able to provide and/or the specific geographical area the Qualified Vendor is willing to serve. A reduction in the service offered and/or the specific geographical area to be served is referred to as "Diminishing Scope of Service."

This policy does not address a Qualified Vendor's intent to request termination of its contract with the Division. For termination of services refer to Division's Provider Policy Manual, Chapter 41, Termination of the Qualified Vendor Agreement Upon Request of theQualified Vendor.

A. BACKGROUND

1. The Division maintains vendor call lists and vendor directories for each District to help match members needing service with available vendors.

2. The vendor directories must identify the vendor's:

    a. Type of service(s), location of offices and service site, and contact information.

    b. Cultural and linguistic capabilities, including all languages (including sign language) offered by the vendor; and

    c. Special accessibility features, including physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities (sensory room, noise-cancelling headphones, patient lift assisted devices, etc.).

3. After a Qualified Vendor has been awarded an agreement with the Division, the Qualified Vendor may amend and/or make subsequent changes to its scope of service. These changes may involve:

    a. Adding a new service;

    b. Expanding the geographical area/district the vendor will serve;

    c. Reducing the amount capacity of service provided or changing the geographical area served; or

    d. Reducing the residential capacity in a specific geographical area/district.

B. ADDING A NEW SERVICE

1. To add a new service to an existing Qualified Vendor Agreement, the Qualified Vendor signatory(ies) must document the request in writing and send the request to the designated Contract Management Specialist. The Contract Management Specialist will review the request and assist the signatory(ies) in amending the agreement to reflect the change.

2. Once the Qualified Vendor has finalized the amendment with the Division's Contracts Unit, the District Network Manager/designee will ask the Qualified Vendor to complete and submit a Qualified Vendor Ready to Provide Services form (DDD-1821A). This form will indicate the service(s) to be provided, the geographical area(s) in which the vendor will provide the new service(s), the cultural and linguistic capabilities, and special accessibility features.

3. The Network Manager/designee will:

   a. Update the District vendor directories to include the service type(s)and geographical area(s) in which the services will be made availableby the vendor.

   b. Update all applicable vendor call lists for the District(s) to include all new services.

   c. Issue an announcement to District Support Coordination personnel informing them of changes made to the District vendor directories and vendor call lists. The notice will include the new vendor, services(s) to be provided, geographical area(s) to be served, the cultural and linguistic capabilities, and special accessibility features; and

   d. Forward the Qualified Vendor Ready to Provide Services form to each Network Manager for each District identified on the announcement.

C. EXPANSION IN GEOGRAPHICAL AREA

1. When the Qualified Vendor wants to expand the geographical area in which it currently provides contracted services:

   a. The Qualified Vendor signatory(ies) must notify the District Network Manager/designee, in writing, of the intent to expand service deliveryto that District or a geographical area within that District.

   b. The District Network Manager/designee may schedule a District specific readiness review meeting with the Qualified Vendor to provide District specific information regarding points of contact.

2. Upon completion of the readiness review meeting and/or receipt of the revised Qualified Vendor Ready to Provide Services form, the District Network Manager/designee will:

a. Update the District vendor directories to include the vendor, service type(s), geographical area(s), the cultural and linguistic capabilities, and special accessibility features that are made available by the vendor;

b. Update all applicable vendor call lists;

c. Issue an announcement to District Support Coordination personnel informing of changes made to the District vendor directories and vendor call lists. include the vendor service(s) to be provided and geographical area(s) to be served; and

d. If applicable, Network will send out the Qualified Vendor Ready to Provide Services form to all other Districts that the Qualified Vendor has designated as willing to serve.

D. DIMINISHING SCOPE OF SERVICE

1. Diminishing scope of service may involve:

   a. A decision by a Qualified Vendor not to accept any new referrals statewide, within a specific District or geographical area; or

   b. Consideration or decision by a Qualified Vendor to discontinue a contracted service statewide, within a specific District or geographical area.

2. Under those circumstances the Qualified Vendor must notify the Division's Contracts Unit, in writing, of its intent to reduce the scope of its services. The written notification must include the reason and must be signed by the authorized signatory(ies) for the Qualified Vendor's agreement.

3. Upon notification of a Qualified Vendor's intent to discontinue services statewide, within a specific District or geographical area, the District Network Manager/designee will immediately notify the Division's Contracts Unit. If needed, the District Network Manager will notify the other District Network Units of the Qualified Vendor's intent.

4. Upon notification of a reduction in scope of service(s) by a Qualified Vendor, the following will occur:

   a. If directed by the Contracts Unit, the District Network Manager/designee will develop a transition plan that outlines the steps and associated timelines for the service(s) to be transitioned to an alternative vendor.

   b. The District Network Manager/designee will send a letter to each member or responsible person notifying him/her of the pending change in network. A copy of the letter will be sent to the member's Support Coordinator.

   c. The District Network Unit will work with Support Coordination to identify

alternative vendor options to meet each member's identified service/ support need.

d. If appropriate, the District Network Manager/designee will request that the Qualified Vendor complete and submit a revised Qualified Vendor Ready to Provide Services form that reflects the service(s) and/or geographical area(s) that the vendor will serve.

5. As needed, the District Network Manager/designee will:

a. Update the District vendor directories to reflect the service type(s) and geographical area(s) the vendor will continue to serve.

b. Update applicable vendor call lists.

c. Issue an announcement to Support Coordination personnel informing them of the changes made to the District vendor directories and vendor call lists to reflect the vendor's diminishing scope of service.

d. If appropriate, the District Network Manager/designee will send out the Qualified Vendor Ready to Provide Services form to the other Districts that the Qualified Vendor has designated as willing to serve.

E. CHANGES IN RESIDENTIAL CAPACITY

1. Per ACOM Policy 436, the Qualified Vendor Network must meet specific criteria to meet the needs of members in different geographical areas. This requirement is met by awarding Homes in specific geographical areas to meet the needs of members.

2. Relocation of residential service sites outside of awarded district or geographical area:

a. 60 days prior to any planned relocations outside the current district/ geographical area for which the site was awarded, the qualified vendor must:

i. Contact the Network Manager to request approval to relocate the site outside of the district/geographical area identified on the award letter for the site, including the reason for the request.

ii. The Network Manager will respond within three business days of this request.

iii. If approved, the Qualified Vendor will follow the Relocation Process.

iv. If the request is denied, the vendor may elect to keep providing in the current awarded area or request a release from service. If the

release is approved, Network will issue a vendor call to identify a new vendor.

b. The vendor will continue to provide the services until the new Qualified Vendor is identified and the home is issued a new site code.

c. Upon completion of the transition to a new vendor, the Qualified Vendor will remove the service site from their contract.

3. Closure of a residential service site(s):

a. 60 days prior to any planned closure of a residential service site(s) the qualified vendor must:

i. Contact the Network Manager and provide written notification including the reason for the planned closure and release of the capacity for the site(s).

ii. The Network Manager will respond within three business days of this request.

iii. Determine with the Network Manager if the site(s) will:

- Be transitioned to a new vendor through the vendor call process,
- Transition members to sites with a new qualified vendor through the vendor call process, or
- Require a transitional roster and material change analysis with Contracts.

b. The vendor will continue to provide the services until the new Qualified Vendor assumes the site or the members have successfully been relocated.

c. Upon completion of the closure, the Qualified Vendor will remove the service site from their contract.

4. Changing capacity of specific service sites:

a. To increase or decrease the capacity of a single site, the Qualified Vendor must submit a request to increase or decrease existing capacity of an existing site, identifying the reason for the requested change to their Network Manager.

b. The Network Manager will respond within three business days of this request.

c. The Network Manager will notify the Qualified Vendor of the approval or denial of the request before any changes are made to the site.

F. RELOCATION PROCESS

1. Contractors who would like to relocate a currently licensed group home must contact the District Network Manager in writing 60 days prior to a permanent relocation of a current home to:

   a. Notify the District of the relocation within the area as identified in the award letter for which the home was originally awarded, or

   b. Obtain approval for relocation outside of the area where the home was awarded.

2. Confirmation that all affected members and their teams are aware of and in agreement with the move should be provided when contacting the Network Manager or designee prior to the move.

3. The Network Manager will respond within three business days of this request to relocate.

4. Site codes do not follow the home being relocated. A new site code must be issued.

5. Network must provide the Qualified Vendor an award letter for relocation.

6. The Qualified Vendor is required to complete all necessary steps, as directed by Network and the Qualified Vendor's contract specialist, to have the home licensed, certified, monitored, and added to their contract prior to members moving.

G. HOME AND COMMUNITY BASED SERVICES (HCBS) VENDOR SEARCH

1. The online Vendor Search application is located on the DDD website.

2. Qualified Vendors must update and maintain the HCBS Vendor Search Directory when they make changes to services, scope of services, cultural and linguistic capabilities, or special accessibility features. Directions to update this information is in the Qualified Vendor Application and Directory System (QVADS) Provider Instructions – Provider Search Maintenance (DDD-PS-000-002).

H. MAINTENANCE TIMEFRAMES

1. The Qualified Vendor must notify the District Network Manager/designee at least 15 calendar days preceding any changes the Qualified Vendor intends to make which affects the Division's vendor call lists or vendor directories, including changes in linguistic capabilities and special accessibility features.

2. Update the HCBS Vendor Search on the Division's website within 10 calendars days prior to a change in scope of services.

CHAPTER 48 - CREDENTIALING OF CONTRACTED PROVIDERS

REVISION DATE: 7/13/2022
EFFECTIVE DATE: May 26, 2017
REFERENCES: AHCCCS AMPM Policy 950

PURPOSE

This chapter outlines the credentialing process for health care providers.

DEFINITIONS

Provider is any person or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

Qualified Vendor is a provider that contracts with the Division for the provision of covered services to members or any subcontractor of a provider delivering services to members.

POLICY

The Quality Management Unit of the Division of Developmental Disabilities (Division) completes credentialing functions to ensure compliance with the Arizona Health Care Cost Containment System (AHCCCS) standards set forth in the AHCCCS Medical Policy Manual, Policy 950. The credentialing of health care providers is delegated to the Division's subcontracted health plans and is monitored by the Division at annual operational reviews. The credentialing of Qualified Vendors is completed by the Division.

A. INITIAL CREDENTIALING

Initial Credentialing occurs before a vendor is approved by the Division's Contracts Unit and is issued a Qualified Vendor Agreement, as follows:

1. The Contracts Unit notifies the Quality Management Unit of a new vendor that has met thecriteria.
2. Quality Management Credentialing Unit staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and RecredentialingProcesses) and create a file.
3. Quality Management staff conduct an on-site assessment.
4. The credentialing file is presented to the Division's Credentialing Committee for approval.
5. Once the vendor has been approved, the Division notifies the vendor within 10 days of the date the Credentialing Committee issues the approval, via letter, that the vendor has been approved and that recredentialing will occur at least every three years thereafter.

B. TEMPORARY/PROVISIONAL CREDENTIALING

If a provider is immediately needed, or meets other criteria in Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) for temporary/provisional credentialing and a contract has been issued before the next Credentialing Committee meeting:

1. The Chief Medical Officer, or Medical Director, reviews the initial credentialing file and makes a determination within 14 calendar days from the request.

2. If the vendor has been approved by the Chief Medical Officer or Medical Director, the Division notifies the vendor that it has been provisionally approved and can initiate authorized services.

3. The vendor's credentialing information will be presented at the next Credentialing Committee meeting for final approval in accordance with Division Policy 950.

C. RECREDENTIALING

Recredentialing occurs at least every three years as follows:

1. Quality Management staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) and create a file.

2. The credentialing file is presented to the Division's Credentialing Committee for approval.

3. If the vendor has been approved, the Division notifies the vendor, via letter, that the vendor has been approved and that recredentialing will occur in three years.

D. CREDENTIALING DENIAL, SUSPENSION OR TERMINATION

1. The Division may deny, suspend, or terminate credentialing for the following reasons:

    a. Not having verification of current insurance

    b. Not being in good standing with state, federal and/or accrediting bodies (if applicable)

    c. Not having current licensure, patterns of licensure compliance issues and/or on-site assessment identifies significant issues

    d. Patterns/Trends regarding complaints/grievances, utilization management, quality of care concerns and/or incidents

    e. Program monitoring and/or certification compliance issues and/or trends

    f. Contract actions, corrective action plans

g. Other contractual obligations not met

h. A credible allegation or determination of fraud, abuse or waste

i. Other concerns relevant to vendor performance and compliance.

2. The reason for the denial, suspension, or termination is documented.

3. The vendor's status is communicated to the Assistant Director, Contracts Management Unit staff, and the Assistant Attorney General for appropriate action.

4. AHCCCS and relevant licensing or certifying boards, law enforcement agencies, and/or protective agencies, are notified of credentialing actions.

CHAPTER 49 RESPONSIBLE DRIVING

REVISION DATE: 12/15/2021, 11/24/2021
EFFECTIVE DATE: May 26. 2017

PURPOSE

The Division of Developmental Disabilities (Division) takes member health and safety very seriously and has an initiative called *Responsible Driving…it's more than what's outside the vehicle* to increase awareness about responsible driving and member safety. The initiative focuses on:

A. Understanding heat-related effects

B. Ensuring safe seating in vans and other vehicles

C. Knowing passengers' needs

D. Completing regular safety checks, both inside and outside the vehicle.

POLICY

A. Vendor Requirements

The Division requires vendors to develop and implement policies and procedures, regarding responsible driving and transporting members, that ensure:

1. Current registration, plates, and insurance for each vehicle
2. Ongoing vehicle maintenance that includes the vehicle climate control systems (air conditioner/heater), and log maintenance for two years
3. Periodic reviews of driving records of employees that drive vehicles to transport members
4. Emergency communication (two-way radio or cell phone) is available for transport
5. Preparedness for emergencies (availability of first aid kit, flashlights, emergency numbers)
6. Safe vehicle boarding and exiting of members
7. Vehicle inspection to ensure passenger safety inside and outside the vehicle prior to, during, and after transport
8. Training of staff on transportation policies/procedures.

The Division encourages providers to use the Transportation Section of form (*DDD-2051A*) *Policy Development Tool*, to self-assess policies and procedures in advance of the Division's review.

Qualified Vendors should share *Responsible Driving Safety Information Fact sheet #6 (DDD-1751AFLYPD)* with providers.

50 VENDOR CALL REQUIREMENTS FOR QUALIFIED VENDORS

REVISION DATES: 05/10/2023, 3/02/22, 3/22/21
EFFECTIVE DATE: February 5, 2018
REFERENCES: A.A.C. R6-6-2101; A.R.S. § 36-551; Qualified Vendor Agreement

PURPOSE

To establish the non-residential and residential Vendor Call requirements for Qualified Vendors and to outline the process for Qualified Vendors to request release from service authorization.

DEFINITIONS

1. "Auto-Assignment" means the process used by the Division to randomly select a Qualified Vendor to provide services to a Member.
2. "Day" means a calendar day unless specified otherwise in this policy. If a due date to complete an action falls on a Saturday or Sunday, the due date is extended to the following Monday. If a due date falls on a state observed holiday, the due date is extended to the following day, excluding weekend days.

3. "Direct Referral" means a phone call, voicemail, and/or email from the Division to one or more Qualified Vendors requesting the Qualified Vendors' availability and ability to provide services for a specific Member or specific group of Members.
4. "Emergency" means an immediate need for services due to an unexpected change in the Member's needs or loss of support system that may result in injury to the Member or exposure to a harmful situation.
5. "Emergency Vendor Call" means a notification sent through Focus inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific Member or specific group of Members, who urgently require services due to an unexpected change in the Member's needs or loss of support system that may result in injury to the Member or exposure to a harmful situation.
6. "Enhanced Behavioral Group Home" means a time-limited service, designed for Members who have been deemed to need intensive behavioral supports, supports the Member's choice to

live in and access opportunities in their communities through services offered in their group home.

7. "Expansion" means adding capacity to the Division's Network of group home services. Expansion capacity is determined by the Division not to exceed six individuals per setting.
8. "Expansion Presentation" means an interview the Division and Members have with a Qualified Vendor(s) that respond to a Vendor Call for Expansion.
9. "Expansion Award Letter" means a written response to the Qualified Vendor from the Division notifying them of the approval to add a new group home with specific parameters to the Division's network.
10. "Focus" means a suite of software applications and programs developed to support the process of delivering ALTCS and State only funded services to eligible Members. Focus includes the management of information regarding Member demographics, service plans, service authorizations, Vendor Calls, and claims. For purposes of this policy, non-residential Vendor Calls are

issued in the Focus Client Application and residential Vendor Calls are issued in the Focus Program Staffing Application (PSA).

11. "Member" means the same as "client" as defined in A.R.S. § 36-551.
12. "Planning Document" means a written statement of services to be provided to a Member, including habilitation goals and objectives, that is developed following an initial eligibility determination and revised after periodic reevaluations.
13. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.
14. "Qualified Vendor" means any person or entity that has a Qualified Vendor Agreement with the Division of Developmental Disabilities.
15. "Receiving Group Home" means a Division group home developed using the Vendor Call process to identify vacant

capacity to be used for Members with an Emergency need for group home services.

16. "Residential Services" means, for the purpose of this policy, the same as Community Residential Setting defined in A.R.S. § 36-551 (15), except this policy does not apply to state-operated services.
17. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a Member for whom no guardian has been appointed.
18. "Vendor Call" means a notification sent through Focus inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific Member or specific group of Members, based on the requirements defined in the Member's Planning Document.

POLICY

A. STANDARD VENDOR CALLS - Non-Residential Services

1. Qualified Vendors shall view Vendor Calls in the Focus Client Application for all services they are approved to provide in their Qualified Vendor Agreements.
2. Qualified Vendors shall designate and authorize staff, with their own individual Focus login, to respond to Vendor Calls within Focus to avoid delays.
3. Qualified Vendors shall respond to each Vendor Call issued in Focus with either a "yes" or "no" response.
4. Qualified Vendors may request additional information about the Member to determine if they can provide the service needed.
    a. Qualified Vendors are not required to respond "yes" to the Vendor Call if they request to review additional information.
    b. If the Member has a current HIPAA release on file, the information will be sent to the Qualified Vendor by secure email within two days by the support coordinator.

c. If the Member does not have a current HIPAA release on file, or the Member does not agree to sign a HIPAA release, the Member's protected health information will be redacted from the Vendor Call (county and zip code will remain).

5. Prior to responding "yes" or "no" to a Vendor Call in Focus, Qualified Vendors shall review the Vendor Call in its entirety to determine if they can meet the needs and preferences of the Member as outlined in the Vendor Call.
   a. If the Qualified Vendor determines that they do have the resources and qualified staff available to meet the Member's needs, the Qualified Vendor shall respond "yes" to the Vendor Call as directed in Focus.
   b. If the Qualified Vendor determines that they do not have the resources or qualified staff available, then the Qualified Vendor shall respond "no" to the Vendor Call.
6. Qualified Vendors may change their response between "yes" and "no" in Focus at any time until the Vendor Call closes.

7. After responding "yes" to the Vendor Call, if a Qualified Vendor determines that they can no longer meet the Member's needs or no longer has qualified staff available, the Qualified Vendor shall change the "yes" response to "no" response in Focus.
8. The Division shall maintain non-Residential Services Vendor Calls as open until the Qualified Vendor is selected or auto-assigned.

B. STANDARD VENDOR CALLS - Residential Services

1. Qualified Vendors shall view Vendor Calls in the Focus PSA for all services they are approved to provide in their Qualified Vendor Agreements.
2. Qualified Vendors shall have designated and authorized staff, with their own individual Focus PSA login, to respond to Vendor Calls.
3. The Division shall ensure standard Vendor Calls remain open for five calendar days.
4. Interested Qualified Vendors that have the available capacity of qualified staff to provide the service as outlined in the Vendor

Call shall respond to the Vendor Call in writing by using the Focus PSA.

5. Prior to submitting a written response to the Vendor Call in the Focus PSA, Qualified Vendors shall review, at minimum, the Planning Document in its entirety to determine if they can meet the needs and preferences of the Member.
6. If the Division has a signed HIPAA release, the Division shall send a secure email with the Member's additional information to the interested Qualified Vendor.
7. If the Division does not have a signed HIPAA release, the Division shall send a secure email to the interested Qualified Vendor with the Member's personal identifiable information redacted.
8. Once the interested Qualified Vendor has reviewed the Member's additional information and determined staff are available and qualified to meet the Member's needs, the Qualified Vendor shall submit a written response to the Division via the Focus PSA as directed in the Vendor Call by the close date.

9. The Qualified Vendor shall respond to the Vendor Call with the following information in the written response to the Division:
    a. Date Qualified Vendor can start services.
    b. Name of the Qualified Vendor.
    c. Contact name.
    d. Contact phone number.
    e. Contact email.
    f. The experience and background to provide the requested services.
        i. The number of years the Qualified Vendor has provided services, or if the Qualified Vendor has not provided services, other pertinent experience; and
        ii. The number and type of homes the Qualified Vendor currently operates for DDD or other state agencies, if applicable.
    g. A written plan to meet identified needs as described in the Member's residential assessment profile.

i. A description of how the Qualified Vendor will provide necessary and Member-specific training to staff.

ii. A description of how the Qualified Vendor will meet the Member’s cultural or linguistic needs.

h. A description of how the Qualified Vendor will meet the Member’s special accommodations, to include:

i. A description of how complex support needs, including medical or behavioral accommodations, will be met, including assurances that the Qualified Vendor will work collaboratively with the Member's health plan to incorporate any required functional behavioral assessment recommendations.

ii. A description of any environmental modifications needed.

i. A time frame by which the service(s) will be delivered.

i. A description of the timeframe that service delivery will begin, which will include the Member or

Responsible Person visiting the residential setting in their preferred geographic location.

ii. A description of all required inspection time frames from the Arizona Department of Health Services (ADHS), the Division's Monitoring, Office of Licensure, Certification and Regulation, and site code issuance not to exceed 90 days, for group home Expansions.

j. Any additional information responsive to the Vendor Call for services.

i. The date by which the Qualified Vendor will offer the Member or Responsible Person a copy of the vendor's policy manual.

ii. A description of how the Qualified Vendor will involve Members in the daily planned activities of the home.

10. The Division may require the Qualified Vendor to provide additional information in the Qualified Vendor's response to

Expansion Vendor Calls for Enhanced Behavioral Group Homes and Receiving Group Homes.

11. After the Vendor Call closes, the Division shall provide the Responsible Person, as applicable, with all responses that meet the needs of the Member as outlined in the Vendor Call.
12. The Division shall notify Qualified Vendors if their written response does not meet the needs specified in the Vendor Call.
13. If a Residential Services Vendor Call closes without identifying a Qualified Vendor, the Division shall conduct Direct Referrals as outlined in Section D. of this policy.

C. AUTO-ASSIGNMENT – Non-Residential and Residential Services

1. If a Member or Responsible Person is unwilling, unable, or does not select a Qualified Vendor from the vendors who respond "yes" to the Vendor Call in Focus for non-Residential Services or submit a written response in the Focus PSA for Residential Services, the Division shall auto-assign the service to a Qualified Vendor.

2. The Division shall include a Qualified Vendor that responds "yes" to the Vendor Call in Focus or submits a written response in Focus PSA in the auto-assignment process as necessary.
3. The Division shall notify the selected Qualified Vendor of the auto-assignment within one business day.
4. The Qualified Vendor shall contact the Member or Responsible Person within one business day of being notified of the Auto-Assignment.

D. DIRECT REFERRALS – Non-Residential and Residential Services

1. The Division shall make Direct Referrals if a Vendor Call does not receive any responses within seven days for non-Residential Services or within five days for Residential Services.
2. The Division shall make Direct Referrals in the Member's preferred geographic area and may extend the search to proximal areas or statewide.
3. The Division shall continue to make Direct Referrals until the service is assigned or is no longer needed by the Member.

4. Qualified Vendors shall respond to the Division's Direct Referrals within one business day.
5. Qualified Vendors who accept the Direct Referral for non-Residential Services shall meet the requirements in Section (A)(5)(a)(b) of this policy.
6. Qualified Vendors who accept the Direct Referral for Residential Services shall meet the requirements in Section (B)(5) of this policy.

E. EMERGENCY VENDOR CALLS – Non-Residential and Residential Services

1. The Division shall issue Emergency Vendor Calls for Members by the using following methods:
   a. Posting the Emergency Vendor Call in Focus for non-Residential Services; or
   b. Posting the Emergency Vendor Call in Focus PSA for Residential Services; and

c. Making Direct Referrals as outlined in Section D(1)(2)(3) of this policy, including contacting Receiving Group homes first for Members needing a group home service.

2. Qualified Vendors shall meet the requirements in D(4)(5)(6) of this policy for responding to Direct Referrals.
3. Qualified Vendors shall respond to Emergency Vendor Calls for non-Residential Services as required in Section A. of this policy.
4. Qualified Vendors shall respond to Emergency Vendor Calls for Residential Services as required in Section B. of this policy.
5. The Division shall maintain Emergency Vendor Calls for Residential Services as open in the Focus PSA for up to three business days.
6. The Division shall maintain Emergency Vendor Calls for non-Residential Services as open until a Qualified Vendor is selected, it is no longer an Emergency need, or the service is no longer needed.
7. Qualified Vendors that respond to the Emergency Vendor Call for Residential Services may meet with the Member or Responsible

Person to coordinate the move if time permits prior to providing Residential Services.

F. SELECTION – Non-Residential and Residential Services

1. The Division shall notify the Qualified Vendor within one business day of being informed of the Member or Responsible Person's selection.
2. The selected Qualified Vendor for non-Residential Services shall complete the following within one business day of being notified of the Member or Responsible Person's selection by the Division:
   a. Acknowledge the service authorization in Focus; and
   b. Contact the Member or Responsible Person to identify a date to start services.
3. The Division shall notify the Qualified Vendors that responded "yes" to Vendor Calls for Residential Services that were not selected within 14 calendar days of the Vendor Call closing.
4. Prior to providing Residential Services, the selected Qualified Vendor shall:
   a. Acknowledge the service authorization(s) in Focus.

b. Verify that the service site is approved by the Division.

c. Attend a meeting with the Member's Planning Team to discuss plans for ensuring a smooth transition for the Member.

5. Following the Member moving into a residential setting, the selected Qualified Vendor shall attend a post-move meeting with the Member's Planning Team to discuss behavioral health supports when necessary, and habilitative outcomes as per timelines required in Division Medical Policy Chapter 1620-E.

G. EXPANSION - All Group Homes

1. The Division shall consider expanding the network when all existing options for identified Member(s) have been exhausted or if a network capacity need has been identified. The Division shall send expansion Vendor Calls to:

a. Meet the needs of a group of Members.

b. Develop new or vacant capacity.

2. The Division shall require new group homes to meet cost effectiveness requirements outlined in the Division's Medical Policy 1620-C.
3. Qualified Vendors shall respond to Expansion Vendor Calls by meeting the requirements as outlined in Section B of this policy.
4. The Qualified Vendor shall participate in Expansion Presentations at the Division’s request.
5. The Qualified Vendor shall develop all materials used in Expansion Presentations, such as brochures, videos, or slide decks, in accordance with Provider Policy Chapter 34.
6. Members shall select the preferred Qualified Vendor based on the collective decision of the Members or Responsible Persons.
7. The Division shall notify the Qualified Vendors that were not selected.
8. The Division shall notify the Qualified Vendor when selected with an Expansion Award Letter.
    a. The Qualified Vendor shall meet all required parameters of the Expansion Award Letter.

b. The Qualified Vendor shall contact the Division with any concerns regarding the parameters of the Expansion Award Letter.

c. The Qualified Vendor Shall provide updates on the status of the Expansion awarded as determined by the Division.

9. The Qualified Vendor shall, within 90 calendar days of receiving the Expansion Award Letter, complete the following:

a. Obtain a home that is owned or leased by the awarded Qualified Vendor within the parameters documented in the expansion award letter.

b. Obtain a license for the group home as required by ADHS.

c. Add the new home address to the service site section in the Division's Contract Administration System.

d. Obtain an HCBS certificate from the Division for the home.

e. Register the home with AHCCCS as a provider type 25-DD group home.

f. Submit an inspection request to DDD Monitoring at DDDMonitoring@azdes.gov and pass the inspection.

g. Obtain a site code by contacting the assigned DDD Contract Specialist.

h. Provide communication at a cadence determined by the Division on recruitment efforts to obtain appropriate staffing levels.

10. The Division may rescind an Expansion Award if the parameters outlined in the Expansion Award Letter are not met, not met timely, or as determined by the Division.

H. REQUEST FOR RELEASE FROM SERVICE AUTHORIZATION – Non-Residential and Residential Services

1. Prior to discontinuing providing services to a Member, the Qualified Vendor shall notify the Planning Team and obtain agreement from the Planning Team.
2. The Qualified Vendor shall submit a request for release from service authorization to the DDD Customer Service Center (CSC) if a request for release is not agreed upon by the Planning Team.
3. The CSC shall process the request and submit it to the District Program Manager (DPM) for resolution.

4. The DPM shall consider the following situations as as applicable when reviewing requests for release of service authorization:
    a. The Qualified Vendor has documented attempts to contact the Member, without success, and services have not been provided.
    b. The Qualified Vendor responded "yes" to the Vendor Call, the Member or Responsible Person subsequently changed the conditions or expectations, and the Qualified Vendor can no longer meet the Member's needs, and services have not been provided.
5. The DPM shall notify the Qualified Vendor of the decision within 21 calendar days.
    a. If the request is denied, the DPM shall include the reasons for denial in the notification.
    b. A Qualified Vendor who disagrees with the decision of the DPM may file a grievance as provided by A.A.C. R6-6-1801 et seq. and A.A.C. R6-6-2201 et seq.

6. The Qualified Vendor shall continue to provide service until a new Qualified Vendor is authorized.

CHAPTER 51 OVERSIGHT AND MONITORING OF DEVELOPMENTAL HOME SERVICES

REVISION DATE: 9/28/22, 2/24/21, 12/26/18

EFFECTIVE DATE: August 8, 2018

REFERENCES: A.R.S. 36-591, 36-592, 36-593.01; A.A.C. R6-6-1001, R6-6-1101

PURPOSE

To outline the roles, responsibilities and requirements of the Division of Developmental Disabilities (Division), Qualified Vendors, and licensees in the provision of Developmental Home Services and Child Developmental Certified Home Services specifically to:

- Outline the experience and expertise, and the training requirements of the Qualified Vendor (agency) staff and licensing workers.
- Establish minimum standards for home studies.
- Provide guidance for entering information into the Division's licensing system, *Quick Connect.*
- Provide guidance for submitting monthly census and changes information.

POLICY

The Division reviews and approves or denies applications and renewals for developmental home licenses to applicants or licensees. The Division contracts with Qualified Vendors for developmental home services and provides monitoring and oversight to ensure compliance with the Qualified Vendor Agreements. Payment for these services are outlined in the Division's Rate Book.

A. DIVISION RESPONSIBILITIES

1. The Division monitors/audits Qualified Vendors at least annually to ensure they have systems in place to provide oversight for compliance to licensing rules, Division Policies and Procedures, Qualified Vendor Agreements, and best practices.
2. New Qualified Vendors are monitored/audited within six months after implementing the service and annually thereafter.
3. The Division shall issue corrective action plans, as necessary, when issues of non-compliance are identified.
4. Protective service agencies (e.g., Department of Child Safety, Adult Protective Services, law enforcement) investigate member abuse, neglect, and exploitation. The Division provides the protective service agencies information to aid in the completion

of an investigation.

5. The Division conducts an onsite visit at each developmental home annually to monitor compliance with health, safety, contractual, programmatic, and quality assurance standards.
6. Prior to initial licensure and annually thereafter, the Division conducts a life-safety inspection. Inspection for an initial license application must occur within nine months of the date the application is submitted to the Office of Licensing, Certification, and Regulation.
7. A new inspection shall be completed if the licensee moves to a new address or completes remodeling.

B. QUALIFIED VENDOR AGENCY RESPONSIBILITIES

1. Through its licensing staff, Qualified Vendors are responsible for recruiting, training, and providing technical assistance and oversight to applicants and licensed providers of developmental home services.
2. Through the established rate model, the Qualified Vendor receives payment from the Division for administrative costs, including but not limited to recruitment, training, technical assistance, and oversight.

a. The Qualified Vendor makes payment(s) to the licensee for direct developmental home services.

b. The licensee may not provide hourly HCBS services to other members while directly responsible for the supervision of members receiving developmental home services.

3. The Qualified Vendor is responsible for reviewing and responding to vendor calls, and once selected by the member/responsible person, assisting with the move in the developmental home.
   a. Up to three Division members or child siblings of members may receive developmental home services in the home.
   b. A license capacity greater than three may only be approved when all children in the home are siblings.
   c. Children deemed likely to be eligible for the DDD program may receive developmental home services upon approval by Division staff.
   d. Qualified Vendors shall ensure new members are not referred to homes with an open licensing investigation, an open protective service investigation, or in a home that has received a notice of an adverse licensing action.

4. The Division pays claims for fingerprinting costs for developmental home license applicants, licensees, and adult household members. Agencies are required to submit information to the Division (using the Fingerprint Clearance Card Tracking Tool) for individuals who have applied for a fingerprint clearance card. The names must be submitted within 10 days of fingerprinting. The name of each applicant, licensee or adult household members should be entered as it appears on their Driver's License or other state or federal identification.

C. EDUCATION AND EXPERIENCE

1. A licensing worker shall have one or more of the following:
   a. A bachelor's degree in a related human services field,
   b. Two years of post-secondary education in a related human services field and two years of directly related work experience, or
   c. A minimum of five years of directly related work experience. Directly related work experience includes work in the field of developmental disabilities, family home licensing, or child welfare.
2. A licensing supervisor shall meet the requirements of a licensing

worker and have two years of supervisory experience or demonstrated leadership experience.

3. A licensing supervisor who is completing the duties of supervisor and licensing worker shall meet the higher requirements of the supervisor.

D. CASELOAD RATIO

A full-time licensing worker may not be responsible for more than 20 licensed homes for training, technical assistance, and oversight.

E. TRAINING

1. Licensing workers and supervisors must have a current Level I Fingerprint Clearance Card and within the first 90 days of employment complete all of the following training areas:
   a. Article 9 (*Requires a certified instructor*)
   b. Articles 10 and 11, as applicable to service delivery to children or adults
   c. Mandated reporting
   d. Incident reporting
   e. Cultural Competency
   f. HIPAA
   g. Provider Manual Chapter 51, Oversight and Monitoring of

Developmental Home Services

h. Prevention & Support (*Requires a certified instructor*)

i. The move process

j. The planning process

k. Introduction to the four developmental disabilities

l. Licensing forms & *Quick Connect*

m. Record keeping

n. Behavior planning

o. Positive behavior support

p. Medication management

q. Life safety rules

r. Member fund management

s. Investigations

t. Guardianship and legal issues

u. The Child and Family Team Process

2. Licensing workers and supervisors are required to attend the Division's Home Studies and Family Assessment Seminar within six months of being assigned to a licensee. In addition, a licensing worker or supervisor is required to complete a minimum of 10 hours of training per year.

3. Licensing seminars sponsored by the Division may be retaken for training credit every three years and count towards the annual training requirements.

F. RECORDS FOR CHILD AND ADULT DEVELOPMENTAL HOMES

1. The Qualified Vendor shall have an organized system to maintain all licensing documents. The licensing file includes training certificates, Department of Economic Security forms, and documentation to verify licensing compliance where applicable. The licensing file shall be kept in locked storage or secure electronic storage when not in use and made available to the Division upon request.
    a. If a licensed provider transfers from one Qualified Vendor to another Qualified Vendor, the sending agency shall provide a copy of the provider's licensing file as outlined in this policy.
    b. The receiving Qualified Vendor shall update any missing items within 30 days of the transfer.
2. The licensing file shall include the following Department of Economic forms:
    a. LCR-1056A, Applicant Statement of Understanding

b. LCR-1040A, Health Self-Disclosure/Physician Statement

c. LCR-1034A, Criminal History Self-Disclosure Affidavit

d. DD-289 or DD-281, Child or Adult Developmental Home Agreement

e. LCR-1031B, Child or Adult Developmental Home Caregiver Assessment Guide (for persons licensed after implementation of this policy)

f. LCR-1054A, signed Initial Application Worksheet

g. LCR-1053A, signed Renewal Application Worksheet

h. Signed Developmental Home Third-Party Agreement, Section 9 F of the Qualified Vendor Agreement

i. LCR-1078A, Developmental Home Application Cover Page

3. The licensing file shall include the following documents as applicable:

a. Training Certificates

b. Fingerprint Clearance Documentation

c. Interstate Central Registry clearance (For child developmental homes; for applicants and household members who have resided outside of Arizona within the prior five years)

d. Three References

e. Marriage License

f. Divorce Decree(s) for the current 10-year period prior to application

g. Birth Certificates (or proof of legal residency)

h. Valid Driver's License for any individuals providing transportation

i. Current vehicle registration for any vehicles regularly used to provide transportation

j. Current vehicle insurance for any vehicles regularly used to provide transportation

k. Verification of income

l. Immunization records for children

m. Interview documentation, pre-licensure and renewal

n. Office of Licensing, Certification, and Regulation (OLCR) Inspection Report

o. Evacuation plan

p. Rabies vaccinations for dogs

q. Copy of the actual license

r. Monitoring Forms

s. Incident Reports

t. Licensing investigations and any corrective action plans

u. Documentation verifying qualifications of any alternate caregivers (Level 1 Fingerprint Clearance Card, CPR, First Aid, Article 9, orientation to member, APS Registry check, and Department of Child Safety (DCS) Central Registry check)

G. POTENTIAL APPLICANTS FOR DEVELOPMENTAL HOME LICENSURE

1. A Qualified Vendor shall inform a potential applicant of the developmental home requirements for licensure under A.A.C. R6-6-1001 or A.A.C. R6-6-1101, *Application for License*. The Qualified Vendor may not "counsel out" or in any way dissuade an applicant who wishes to apply to the Division for a developmental home license.
2. If the Qualified Vendor determines it is not able to work with an applicant who wishes to apply for a license, the determination shall not be based on race, religion, national origin, sex, sexual orientation, gender identity, or a similar protected class.
3. A Qualified Vendor shall assist any applicant it declines to work

with to find an alternative vendor, or if no alternative vendor is available, refer the applicant to the Division. The Qualified Vendor shall transfer any application information to the alternative vendor or Division, as applicable.

4. Applicants for licensure may be married or unmarried persons. No more than two single individuals shall be licensed at the same address if they both plan on providing care. This could include a cohabiting couple, a set of adult siblings, a parent and adult child, or roommates who wish to be licensed together. Married applicants shall be licensed jointly unless a married applicant applies to be licensed individually and one or more of the following applies to the applicant's spouse:
   a. Expected to be absent from the household for nine or more of the following 12 months due to employment, military service, or other planned absence;
   b. Legally separated and living in another residence and the applicant has the right to exclusive use of the residence; or
   c. Medically or physically incapacitated to the degree that the spouse is unable to provide care for a member.
5. The Qualified Vendor is responsible to provide or arrange

pre-licensure and annual training for applicants. Pre-licensure training must meet the specific content requirements outlined by the Division. The Qualified Vendor is responsible to ensure that the licensee receives a pre-move orientation to each member's needs and planning documents.

H. HOME STUDY, HOME VISITS, AND TECHNICAL ASSISTANCE

1. Prior to licensure, the applicant and household members shall participate in interviews and assist the licensing worker to evaluate the applicant with respect to character, family stability, and the ability to care for individuals with developmental disabilities. Each applicant and household member should be interviewed individually. Married or cohabiting couples should be interviewed at least once together. If the applicant has children in the home, children should be interviewed, if possible. All interviews should be conducted by the licensing worker in person. Information gathered during the interviews is summarized and included in the Home Study submitted through *Quick Connect*.
2. The licensing worker shall visit the home monthly to provide technical assistance, support to the licensee, and ensure

compliance with licensing rules, Division policies and procedures, the Qualified Vendor Agreement, the Third-Party Developmental Home Agreement, and best practices. The licensing worker shall document all visits in the Division's licensing data system, *Quick Connect.* If there are no members placed in the home, only quarterly (in person or virtual) visits are required.

Note: New move visits shall be completed within seven days. For licensees providing care for the first time, a licensing worker shall visit the home once per week during the first four weeks of move.

3. A comprehensive licensee visit shall be completed every quarter using the Developmental Home Compliance Review form (LCR-1079A). A visit includes the following:
   a. A review of any expiring certifications or documents,
   b. An inspection of the premises to ensure compliance with the licensing and life-safety rules,
   c. A review of the file (progress reports, medication logs),
   d. A discussion of any move challenges including methods used for managing inappropriate behaviors,

e. A discussion about the progress of the member on their habilitation goals,

f. A discussion of any changes or upcoming changes in the household,

g. A discussion of past or upcoming appointments,

h. A review of transportation arrangements,

i. A review of any alternate supervision plans,

j. A discussion of member funds,

k. A discussion of member choice,

l. A discussion of member social and recreational activities, and

m. Interaction or observation of the member in the home setting.

4. Quarterly visits are based on a calendar year. Quarterly visits shall be completed by March 31, June 30, September 30, and December 31. At least one unannounced home visit shall be completed each calendar year using the Abbreviated Developmental Home Compliance Review form (LCR-1079B).

5. Visits shall be documented in *Quick Connect* within 10 business days of the visit. Documentation shall include:

a. Date of the visit,

b. Type of visit (scheduled or unannounced),

c. Length of the visit,

d. Location, and

e. Individuals contacted during the visit.

f. A general visit summary that includes:

i. A summary of key discussion points during the visit,

ii. A statement identifying the monitoring tool used during the visit,

iii. A statement of whether there were any licensing violations noted and a statement indicating any calls to protective services as a result of the visit,

iv. A statement of any corrective actions needed including a notation of any repeat issues,

v. A summary of any items requiring follow-up, and

vi. Verification that the follow-up was completed from the last review.

6. Annual renewal is an annual reassessment of character, family stability, and the ability to care for individuals with developmental disabilities. The annual renewal may be combined

with a quarterly monitoring visit. A renewal visit includes interviews with licensees. During the renewal visit, the licensing worker collects or reviews documents needed for the renewal application. Members should not be identified by name in licensing home studies. Members should be identified by initials and Assists ID only. Renewal applications must be submitted through *Quick Connect* at least 30 days prior to the expiration of the license.

7. A renewal application and home study may be submitted for a license applicant whose license has been voluntarily closed or expired for less than one year. An applicant whose license has expired or voluntarily closed for more than one year must submit an initial application and home study.
8. If a licensing investigation is requested by the Division due to a complaint or significant compliance concern, the Qualified Vendor shall contact the licensee and initiate an investigation within 10 days. The Qualified Vendor shall submit a report to OLCR within 21 days using the Licensing Investigation Template form (LCR-1080A).
9. At all visits a Notice of Inspection Rights form (LCR-1005A) shall

be reviewed and completed. The licensee shall receive a copy of any monitoring forms completed during the visit.

I. DEVELOPMENTAL HOME CENSUS AND REPORTING CHANGES

The Division manages the Network capacity to support its membership. In order to ensure that the capacity is accurate, the Qualified Vendor shall submit a monthly census of each developmental home it has an agreement with no later than the last day of the reporting month. The census shall be on the Division's approved Developmental Home Census Report form and submitted through secure email to DDDDevelopmentalHomeCensus@azdes.gov. The Developmental Home Census Report form may be found here: https://des.az.gov/sites/default/files/Developmental_Home_Census_Template_100920.xlsx Additionally, the Qualified Vendor shall notify the Division of all changes in member moves, including internal moves (within the agency) or external moves (to another vendor). The moves shall be reported on the same form as the monthly census and submitted to the same email address.

J. LICENSEE

1. The licensee is required to maintain a license issued by the Division and ensure that the licensee maintains compliance with

the terms of the license and with applicable rules. The licensee provides direct care to Division member(s) as outlined in the member's planning documents and under the Third-Party Developmental Home Agreement.

2. The licensee selects a Qualified Vendor based on individual preference; however, licensee may not transfer from one Qualified Vendor to another if the license is within 60 days of expiration. If the licensee is on a corrective action plan, a transfer requires written approval of the sending Qualified Vendor, the receiving Qualified Vendor, and the Division.
3. The licensee shall comply with all home visits conducted by the licensing worker or the Division.
4. Prior to initial licensure, all child and adult developmental home applicants must have CPR and First Aid training, taught by an instructor certified by a nationally recognized entity such as the American Red Cross, the American Heart Association, or the National Safety Council, that requires the applicant to demonstrate mastery of skills in person to the instructor. In addition, receive training (with supporting documentation verifying completion) in all of the following core topics and

subtopics, totaling a minimum of 18 hours of course or instruction time (Courses marked with an asterisk [*] are available on the Division's website):

a. Article 9, including member rights, taught by a certified instructor.

b. DDD Philosophy and Mission Statement*

   i. DDD Mission Statement.

   ii. Individual and family involvement in making choices and expressing preferences.

   iii. Equal access to quality services and supports for all individuals.

   iv. Individuals as welcomed, participating, and contributing members in all aspects of family and community life.

   v. The rights of all individuals and the preservation of their worth, value, and dignity.

c. Introduction to the Four Developmental Disabilities*

   i. What are the Four Developmental Disabilities?

      - Cognitive/ Intellectual Disability
      - Epilepsy

- Cerebral Palsy
- Autism

ii. Diagnostic Criteria

iii. Functional Criteria

iv. Substantial Functional Limitation(s)

v. Treatment

d. The planning process and skill building*

i. The planning process

ii. Components of a plan

iii. Long- and short-term goals

iv. Measurable objectives

v. Data collection procedures and systems

vi. Progress reports

vii. Assessing strengths and needs

viii. Methods of teaching

ix. Types of reinforcement

x. The use of teaching strategies/plans

e. Medication Administration*

i. Medication storage

ii. Medication container and label

iii. The medication logs

iv. Correct dosage

v. Forms of medication

vi. Routes of medication administration

vii. Medication error procedures

f. Incident Reporting and Reporting Abuse, Neglect, or Exploitation*

i. Understanding the incident reporting process.

ii. Identifying emergency situations and signs of abuse.

iii. Understanding mandatory reporting requirements.

iv. Demonstrating how to complete an incident report.

g. Confidentiality/HIPAA*

i. Limits to access to member records and personally identifiable information.

ii. Agency procedures designed to protect/safeguard member confidentiality.

iii. Procedures for obtaining consent prior to the release of information.

iv. Review of ARS 36-568.01.

h. Choking and Aspiration*

i. Preventing aspiration and choking

ii. Common issues

iii. Assessment

iv. Intervention and prevention strategies

i. Principles of Positive Behavior Support

i. Prevention vs. intervention

ii. Recognizing cues

iii. Reinforcing appropriate behavior

iv. Redirection

v. Consistency

vi. Clear communication

vii. Evaluating the environment

viii. Defensive positioning

ix. Providing opportunities for choices and decision-making

j. Cultural Competency (covered for child developmental home applicants in the ADCS/Foster Parent College Based Pre-Service Training Program).

k. Client Funds Training*

L. Documentation and Progress Reporting Requirements and

vendor policies.

l. Review Article 10 or 11, as applicable to the populations served.

m. Review of the Child or Adult Developmental Home Third-Party Agreement.

n. Supporting positive relationships with family members, schools, or day programs, and professional communication (covered for child developmental home applicants in the ADCS/Foster Parent College Based Pre-Service Training Program).

5. In addition to the DDD specific training noted above:

a. Applicants for a child developmental home license must complete the DCS/Foster Parent College-Based Pre-Service Training Program.

b. If required in a member's planning documents, applicants must complete the training in Prevention and Support.

6. Licensees are required to complete 10 hours of training annually. Training required to maintain certifications (CPR, First Aid, and Article 9) may be counted for up to four hours of the annual training.

7. When reopening a license that has been closed for one year or less, applicants must complete a minimum of 10 hours of training. If the license has been closed for over one year, applicants must complete a minimum of 18 hours of training covering the topics required for initial applicants.

K. CHILD DEVELOPMENTAL CERTIFIED HOMES

1. A Child Developmental Certified Home (CDCH) is a foster home licensed by the DCS that has been certified by the Division to provide care for a specific child or children with developmental disabilities. A CDCH must meet the same requirements as a child developmental home and maintain compliance with foster care licensing rules. When a Child Developmental Home Certification is issued, the foster care license is restricted to the specific child or children placed in the home. Additional children may only be placed in the home with the approval of DCS and DDD. A CDCH may provide care for up to five children in care with no more than three children with developmental disabilities.
2. Once the certification is issued, the DDD qualified vendor (certifying agency) is responsible for monitoring compliance with child developmental home requirements outlined in A.A.C

R6-6-1001 et. seq. (Article 10). The DCS licensing agency is responsible for monitoring compliance with foster care licensing rules. A CDCH provider may be supported and monitored by a single agency responsible for both DDD and DCS requirements or a CDCH provider may be monitored by a DDD qualified vendor for the DDD certification requirements while a different agency monitors the DCS licensing requirements. The DDD qualified vendor is required to conduct monitoring visits to the home according to the same requirements outlined in this chapter for child developmental homes.

3. Prior to applying for a CDCH, the DDD certification worker must confirm that the child is eligible for DDD services and approved for Child Developmental Certified Home Services. This must be confirmed by contacting DDD Network staff in the District responsible for support coordination for the child.

L. INITIAL APPLICATION FOR CDCH CERTIFICATION

1. Initial CDCH applicants must complete 18 hours of training covering the topics required for a child developmental home as listed in this policy. To apply for a CDCH certification, the following documents shall be submitted to OLCR:

a. LCR-1086A, Application for Child Developmental Home Certification,

b. LCR-1087A, Child Developmental Certified Home Application Cover Page,

c. LCR-1056A, Applicant Statement of Understanding signed by the applicants and all adult household members,

d. LCR-1085A, Adult Protective Services Records Check Request for the applicants and all adult household members,

e. CSO-1232A (DCS form), a copy of the most recent health self-disclosure for the applicants and all adult household members,

f. CSO-1269A (DCS form), a copy of the most recent physician statement for the applicants and all adult household members,

g. CSO-1229 (DCS form), a copy of the most recent Criminal History Self-Disclosure for the applicants and all household members,

h. LCR-1033A, Life-Safety Inspection Request, and

i. Certification Study.

2. For DDD vendors who are also responsible for the foster care license, the CDCH study may be submitted through *Quick Connect*. In all other circumstances, the CDCH study shall be submitted to OLCR via email. The CDCH study shall contain the following:
    a. A statement of the circumstances of the request, including a statement that DDD/Network has approved certification for the specific child. Identify the child by initials and Assists ID only.
    b. A summary of the training completed. Training must reflect the minimum of 18 hours of child developmental home training requirements outlined in this policy.
    c. A summary of the child's needs.
    d. A summary of how the family will meet the child's needs including:
        i. A description of the applicant's work hours.
        ii. Alternative supervision plan which includes only caregivers meeting HCBS requirements.
        iii. Transportation plan including a vehicle inspection.
        iv. A summary of any special care needs for other

members of the household including placed or biological children.

e. A description of the home, sleeping arrangements, and a summary of the OLCR inspection.

f. A summary of the fingerprint clearance card status and protective service checks completed on the applicants and household members.

g. Recommendation for Child Developmental Home Certification.

M. RECORDS FOR CHILD DEVELOPMENTAL HOME CERTIFICATION

1. The Qualified Vendor shall have an organized system to maintain all certification documents. The licensing file includes training certificates, Department of Economic Security forms, Department of Child Safety forms, and documentation to verify certification compliance where applicable. The licensing file shall be kept in locked storage or secure electronic storage when not in use and made available to the Division upon request.

2. Forms:

   a. LCR-1086A, signed Application for Child Developmental Home Certification

b. LCR-1056A, signed Applicant Statement of Understanding

c. LCR-1085A, Request for Adult Protective Services Records Check

d. LCR-1033A, Request for Life Safety Inspection

e. CSO-1232A (DCS form), Health Self-Disclosures obtained from the DCS licensing file

f. CSO-1269A (DCS form), Physician Statements obtained from the DCS licensing file

g. CSO-1229A (DCS form), Criminal History Self-Disclosure forms obtained from the DCS licensing file

h. LCR-1087A: Child Developmental Certified Home Application Cover Page

i. Signed Developmental Home Third Party Agreement, Section 9 F of the Qualified Vendor Agreement

3. Verification documents and other requirements:

a. Training Certificates

b. Fingerprint Clearance Documentation

c. Three References (copies of references may be obtained from the foster care licensing file)

d. Valid Driver's License for any individuals providing

transportation

e. Current Vehicle Registration for any vehicles regularly used to provide transportation

f. Current Vehicle Insurance for any vehicles regularly used to provide transportation

g. Immunization records for non-placed children

h. OLCR inspection report

i. Evacuation plan

j. Rabies vaccinations for dogs

k. Copy of the actual license

l. Monitoring Forms

m. Incident Reports

n. Licensing/Certification investigations and any corrective action plans

o. Documentation verifying qualifications of any alternate caregivers (Level 1 fingerprint clearance card, CPR, First Aid, Article 9, orientation to member, APS Registry check and DCS Central Registry check)

N. RENEWING THE CERTIFICATION

1. A foster care license is issued for a two-year period. The initial

certification will be in effect for a minimum of one year, and then expire on the same day and month as the foster care license expiration. The certification will expire annually thereafter.

2. The DDD certifying agency is responsible for monitoring renewal timeframes and renewing the certification as needed.
3. To renew the certification:
    a. A renewal application must be submitted at least 30 days prior to the expiration of the certification.
    b. 10 hours of training must be completed. Training required to maintain certifications (CPR, First Aid and Article 9) may be counted for up to four hours of the annual training.
    c. A Life-Safety Inspection must be conducted annually prior to each renewal.
4. To renew the CDCH, the following documents shall be submitted to OLCR:
    a. LCR-1086A, Application for Child Developmental Home Certification,
    b. LCR-1087A, Child Developmental Certified Home Application Cover Page,
    c. LCR-1056A, Applicant Statement of Understanding, signed

by the applicants and all adult household members,

d. CSO-1232A (DCS form), a copy of the most recent health self-disclosure for the applicants and all adult household members, if updated during the certification period,

e. CSO-1269A (DCS form), a copy of the most recent physician statement for the applicants and all adult household members, if updated during the certification period,

f. CSO-1229 (DCS form), a copy of the most recent Criminal History Self-Disclosure for the applicants and all household members, if updated during the certification period, and

g. LCR-1033A, Life-Safety Inspection Request (60 days prior to expiration).

5. Certification Home Study:

a. For DDD vendors who are also responsible for the foster care license, the CDCH study may be integrated into the license renewal and submitted through *Quick Connect*.

b. For DDD vendors responsible for the certification only, the CDCH study is submitted to OLCR via email and the foster

care licensing agency enters that data into *Quick Connect* once reviewed and approved by OLCR.

c. The certification renewal study should follow the same general format as the initial study outlined above.

O. TERMINATING A CERTIFICATION

A CDCH is terminated when the child for whom the CDCH certification was issued moves from the home or if the foster care license is terminated. After a child leaves the home an amendment must be completed to close the certification.

CHAPTER 52 HABILITATION STAFFING SCHEDULE REQUIREMENTS AND ANNUAL REVIEW

REVISION DATE: 8/10/22

EFFECTIVE DATE: April 3, 2019

REFERENCES: Division Medical Policy 1620-C

PURPOSE

To establish the duties and responsibilities of Qualified Vendors regarding the preparation and submission of Daily Habilitation Staffing Schedule for Group Homes and Individually Designed Living Arrangements/Supported Living (IDLA) unless otherwise noted.

POLICY

A. CRITERIA

1. Qualified Vendors are responsible for the following:

    a. Maintaining the staffing level as indicated in the approved staffing schedule, and

    b. Submitting all staffing schedules to the Division for review and approval through the Program Staffing Application in Focus.

B. CREATING AND SUBMITTING STAFFING SCHEDULES

1. Qualified Vendors are responsible for creating and submitting all staffing schedules that are determined based on the collective needs of all members at that site as follows:

    a. Five business days prior to all known or planned events (e.g., members moving in/out, school breaks, holidays).

    b. Within two business days of all unplanned events (e.g., member

hospitalized, illness, or vacation).

2. Submit a new Master Schedule for changes in:

   a. Occupancy. The number of Division members or other individuals with developmental disabilities who currently live in the home.

   b. Capacity (requires Network pre-approval) for group homes only.

   c. Site Code and/or address.

   d. Any modifications to the staffing schedule exceeding 30 days resulting in a change to the range as outlined in the Division's Rate Book.

   e. Home closure.

3. Submit a new temporary schedule for any modifications to the staffing schedule for less than 30 days resulting in a change to the range as outlined in the Division's Rate Book, including but not limited to:

   a. Acute behavioral health need(s).

   b. Acute physical health need(s).

   c. School/holiday breaks.

   d. Short-term absence from a day or work program.

   e. Scheduled or unscheduled short-term absence from the home.

4. If there is an emergency:

   a. Staff the home as appropriate for the immediate circumstance.

   b. When the emergency event modifies the staffing range notify:

i. Network Manager and/or designee by the next business day and submit a revised staffing schedule with a detailed explanation.

ii. Member's support coordinator as soon as possible, but no later than the next business day.

5. Complete Summary Comments:

a. Identify the member(s) by first and last name.

b. Indicate member(s) who:

i. Have an approved behavior plan,

ii. Have a work and/or day program schedule,

iii. Need additional staffing supports, as outlined in the Planning Documents, for needs including but not limited to:

1) Behavioral Health

2) Physical Health

3) Community

4) Overnight

c. Explain the reason for the schedule change, and

d. Provide specific details regarding the members' staffing needs.

C. ANNUAL RESIDENTIAL REVIEW

1. Annually the Qualified Vendor shall, upon invitation, meet with Network to review daily habilitation staffing schedules and includes the following:

a. Vacancies and Placement Profiles.

b. Review information regarding potential housemates.

c. Additional staffing supports:

i. Compare census to the schedule to ensure it is accurate.

ii. Review the information in the comment section regarding additional staffing supports.

iii. Verify documentation that the additional staffing supports are approved by the planning team, including any behavioral health supports.

d. Capacity.

e. Residents not funded through the Division, including individuals who are involved with the Department of Child Services.

f. Cost effectiveness. The review should result in mutually agreed upon appropriate and cost-effective supports that meets the physical health, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting; and

g. Summary comments.

2. Within 14 calendar days following the annual review, submit all agreed upon updates to the Division.

3. Maintain all approved staffing schedules.

D. NETWORK APPROVAL

1. The Network is responsible for the following:

a. Create or revise a staffing schedule.

b. Review staffing schedules submitted by the Qualified Vendor.

c. Approve each staffing schedule as appropriate.

d. Upon approval of an IDLA – HID Staffing Schedule:

   i. Keep the signed documents with original signatures, and

   ii. Provide a copy to the Qualified Vendor.

CHAPTER 53 SUPPORTING CHILDREN IN CARE OF THE DEPARTMENT OF CHILD SAFETY IN COMMUNITY RESIDENTIAL SETTINGS

REVISION DATE: 1/10/2024

REVIEW DATE: 5/12/2023

EFFECTIVE DATE: December 7, 2022

REFERENCES: A.R.S. 36-551(12), (15), (23), (33) (Version 2)

PURPOSE

To outline the roles and responsibilities of Qualified Vendors, the Department of Economic Security, Division of Developmental Disabilities (DDD or Division), and the Department of Child Safety (DCS) for supporting children in care of DCS in Community Residential Settings. This includes providing access to Community Residential Settings to children with intellectual and developmental disabilities who are likely eligible for DDD and their siblings.

DEFINITIONS

1. **"**Child Developmental Home**"** means the same as defined in A.R.S. 36-551(12).
2. **"**Community Residential Setting" means the same as defined in A.R.S. 36-551(15).
3. "Group Home" means the same as defined in A.R.S 36-551(23).
4. "Likely Eligible Child**"** means a child screened by DCS, using a tool

developed by the Division, and determined likely eligible for the Division based on that tool.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
6. "Nursing-Supported Group Home" means the same as defined in A.R.S. 36-401 and 36-551 (33) (Version 2).

POLICY

A. QUALIFIED VENDOR ROLES AND RESPONSIBILITIES

Qualified Vendors shall do the following:

1. Accept referrals in community residential settings for Members, Likely Eligible Children, and siblings of Members and Likely Eligible Children, from the Division during business hours and from DCS after business hours or as authorized by the Division.
2. Ensure Members and Likely Eligible Children receive developmental home services in the same setting as their siblings, when possible.
3. Do not permit siblings to reside in DDD Group Homes or Nursing-Supported Group Homes.
4. Follow the requirements in the Qualified Vendor Agreement and Division Policy when delivering services to children in care of

DCS.

5. Do not make referrals to licensees of child developmental home services with open DCS investigations, licensing concerns, or do not have existing licensed capacity.
6. Only accept referrals in Group Homes or Nursing-Supported Group Homes where there is current existing capacity approved by the Division.
7. Submit claims to DCS for services in Community Residential Settings for:
    a. Members who are not eligible for ALTCS;
    b. Likely Eligible Children; and
    c. Siblings of Members and Likely Eligible Children.
8. Submit claims for authorized services as outlined in the Division's rate book and billing manual for Members who are eligible for ALTCS.
9. Submit non-Member incident reports to dddolcr@azdes.gov.
10. Submit Member incident reports in accordance with Provider Policy Chapter 70.

B. DEPARTMENT OF CHILD SAFETY ROLES AND RESPONSIBILITIES

Pursuant to intergovernmental agreement, DCS shall do the following:

1. Screen children in care of DCS for signs of possible intellectual or developmental disabilities using the Division's Likely Eligible Tool (LET) available in the DES Document Center.
2. Provide the completed LET, a signed Authorization for Disclosure of Protected Health Information, any records that demonstrate potential signs of an intellectual or developmental disability, any identified specialized care needs, and request assistance from the Division within one business day of completing the LET.
3. Notify the Division of the Community Residential Setting selected within one business day of receipt of the residential services options.
4. Be responsible for identifying residential services options for all DCS involved children after business hours and notifying the Division by the next business day of the child moving into the residential setting.
5. Ensure Likely Eligible Children receive developmental home services in the same setting as their siblings and do not permit siblings to reside in DDD Group Homes or Nursing-Supported Group Homes.
6. Be responsible for identifying residential service options for

siblings of Division Eligible or Likely Eligible Children who require a new living arrangement due to disruption of a Community Residential Setting, including when a Likely Eligible Child is found ineligible and needs a new living arrangement due to disruption.

7. Coordinate all physical and behavioral health services necessary to support non-ALTCS children in the Community Residential Setting.
8. Pay claims for services in Community Residential Settings that meet DCS payment standards submitted by Qualified Vendors for:
    a. Members not eligible for ALTCS,
    b. Likely Eligible Children, and
    c. Siblings of members and Likely Eligible Children.
9. Visit the child(ren) monthly in the Community Residential Setting.
10. Report any potential licensing or contractual violations to the Division's Office of Licensing, Certification and Regulation (OLCR) or the Arizona Department of Health Services (ADHS) as appropriate to the setting.
11. Submit Division and or AzEIP eligibility application within 90 days

of the Likely Eligible Child moving into a Community Residential Setting.

12. Report updates on the DCS LET tracking form for Likely Eligible Children.

C. DIVISION ROLES AND RESPONSIBILITIES

Pursuant to intergovernmental agreement with DCS, the Division shall do the following:

1. During business hours, on behalf of DCS, identify Community Residential Settings for Members, Likely Eligible Children, and siblings of Members and Likely Eligible Children, as allowable in this policy.
2. Monitor compliance of Community Residential Settings as required and report issues or concerns to DCS, OLCR, and ADHS as appropriate.
3. Report any licensing issues to ADHS for children residing in Group Homes and Nursing-Supported Group Homes and to OLCR for children in DCS care who reside in Child Developmental homes.
4. Restrict a Child Developmental Home license if a Likely Eligible Child is found to be ineligible for the Division.

54 GROUP HOME REQUIREMENTS

REVISION DATE: 2/7/2024
REVIEW DATE: 8/30/2023
EFFECTIVE DATE: July 19, 2023
REFERENCES: 42 § C.F.R. 441.300-441.310; A.R.S. § 13-3602; A.R.S. § 36-401; A.R.S. §§ 36-501 et seq.; A.R.S. § 36-551; A.A.C. R9-10-2206; A.A.C. R9-10-101; A.A.C. R6-6-101; A.A.C. Title 6, Article 8; A.A.C. Title 6, Article 9; A.A.C. Title 6, Article 15; A.A.C. Title 6, Article 21; Qualified Vendor Agreement; Behavior Supports Manual Chapter 400; Behavior Supports Manual Chapter 500

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Group Home services for Division Members.

DEFINITIONS

1. "Acuity" means a patient's need for medical services, nursing services, or behavioral health services based on the patient's medical condition or behavioral health issue.
2. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
3. "Adult" means a person aged 18 years or above.
4. "Behavior Plan" means a written plan of services and therapeutic interventions based on a complete assessment of a Member's developmental and health status, strengths and needs

that are designed and periodically updated by the multispecialty, interdisciplinary team.

5. "Behavioral Health Professional" means
   a. An individual licensed under A.R.S. § 32, Chapter 33, whose scope of practice allows the individual to:
      i. Independently engage in the practice of behavioral health as specified in A.R.S. § 32-3251, or
      ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as specified in A.R.S. § 32-3251 under direct supervision as specified in A.A.C. R4-6-101.
   b. A psychiatrist as specified in A.R.S. § 36-501.
   c. A psychologist as specified in A.R.S. § 32-2061.
   d. A physician.
   e. A behavior analyst as specified in A.R.S. § 32-2091.
   f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
   g. A registered nurse:
      i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services.

6. "Behavioral-Supported Group Home" or "BSGH" means a time-limited service, designed for Members who have been deemed to need intensive behavioral support that supports the Member's choice to live in and access opportunities in their communities through services offered in their Group Home.
7. "Business Hours" means the office hours that state offices are kept open for transaction of business from 8:00 a.m. to 5:00 p.m., from Monday through Friday, excluding holidays, furlough closure; or otherwise required by law, as per A.R.S. § 38-401.
8. "Child" means a person under the age of 18.
9. "Clinical Oversight" means monitoring provided by an independently licensed BHP, by virtue of education, training and experience, is capable of assessing the behavioral health history of a Member to determine the most appropriate treatment plan.
10. "Clinical Oversight Meeting" means a professional staffing that occurs at least monthly, for the purposes of monitoring the

Member's progress and the Qualified Vendor's compliance with Division policy and BSGH service specifications.

11. "Court-Ordered Evaluation" or "COE" means an evaluation ordered by the court as per A.A.C. R9-21-101.
12. "Court-Ordered Treatment" or "COT" means treatment ordered by the court as per A.A.C. R9-21-101.
13. "Direct Support Professional" or "DSP" means a person who delivers direct support in Home and Community-Based Services with current training according to the training and/or certification or licensing requirements of the Home and Community-Based Service(s) they provide. DSPs support Members to develop independent skills and be included in their communities. DSPs may include Developmental Home Providers and therapists who provide direct support.
14. "Emergency Receiving Home" means a Division Group Home developed using the Vendor Call process to create vacant capacity to be used for Members with an emergency need for Group Home services.

15. "Functional Behavior Assessment" means a comprehensive assessment consisting of different observations of the member in one or more settings, with one or more caregivers; and includes a comprehensive review of historical documents (e.g., Planning Documents, evaluations, progress reports, Individualized Education Program, data collection), indirect and direct assessment, and recommendations for treatment.
16. "Group Home" or "Home" for the purposes of this policy means the same as defined in A.R.S. § 36-551.
17. Home and Community-Based Services Settings Final Rule means the requirements set forth by 42 C.F.R. §§ 441.300-441.310 for HCBS settings to ensure individuals have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Nesting" means a period of independent caregiving, usually 24 to 48 hours for the Member while they are in the Developmental Home, Nursing Supported Group Home, or Intermediate Care

Facility and the parent or caregiver has the oversight of medical staff during that time period.

20. "Nursing Supported Group Home" means the same as defined in A.R.S. § 36-401.
21. "Order of Protection" means any injunction or other court order that is issued for the purpose of preventing violent or threatening acts or harassment against, contact or communication with or physical proximity to another person.
22. "Person-Centered" means an approach to planning designed to assist the Member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.
23. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
24. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member,

and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

25. "Predictable Staffing" means a consistent schedule of direct support professionals that meets the needs of the Member(s) and the Member(s) know and expect to be working with them.
26. "Program Review Committee" or "PRC" means the assembly of designated individuals that review and approve Behavior Plans meeting the criteria outlined in Article 9 prior to implementation.
27. "Qualified Vendor" means any person or entity that has a Qualified Vendor Agreement with the Division of Developmental Disabilities.
28. "Residential Services" means the same as Community Residential Setting defined in A.R.S. § 36-551 (15), except this policy does not apply to state-operated services.
29. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a

developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed as per A.R.S. § 36-551 (39).

POLICY

A. REQUIREMENTS FOR ALL GROUP HOMES

1. The Qualified Vendor shall provide a safe, stable, individualized environment that is Person-Centered with:
   a. Predictable staffing;
   b. Daily routines;
   c. Promotes independence, autonomy, Member choice and control as much as possible while assuring Member health and safety; and
   d. Offers and supports social and leisure activities based on what the Member likes to do, supports relationships that are important to the Member by enabling frequent contact with people who care about the Member, and supports Members with integrating into their communities.
2. Qualified Vendors shall only accept Member referrals for Residential Services from the Division.

3. Qualified Vendors operating standard Group Homes, Emergency Receiving Homes, and Nursing Supported Group Homes in which a Member resides shall ensure:
    a. An approved Behavior Plan is in place for Members as outlined in the Division Behavior Support Policy Manual and A.A.C. R6-6-904 within 90 days of move-in and approved annually; and
    b. Have staff that are trained and monitored to implement a Member's Behavior Plan as written.
4. Qualified Vendors shall ensure all Group Homes operated by the Qualified Vendor in which Members reside are:
    a. Licensed by the Arizona Department of Health Services (ADHS) and approved by the Division;
    b. Assigned a site code by the Division for each Group Home;
    c. Meet the requirements of the Home and Community Based Services Final Rule; and
5. Qualified Vendors shall allow adult and child Members to live in the same Group Home operated by the Qualified Vendor if:

a. Approved by the Responsible Person(s) of the child and adult; and

b. Documented in the Planning Document of both the child and adult.

6. Staff of all Group Homes operated by the Qualified Vendor shall accompany and provide support to Members until admitted as inpatient to a hospital.

7. The Qualified Vendor providing Group Home services shall ensure Members are accompanied by Group Home staff during emergency transport if available.

8. Qualified Vendors shall participate in discharge planning and all staffings with the hospital or crisis facility while a Member is inpatient.

9. Qualified Vendors shall participate in transition meetings for Members moving into or from a Group Home.

10. The Qualified Vendor shall accept the Member back to the Group Home as determined by the Planning Team upon discharge from the hospital or crisis facility.

11. The Qualified Vendor shall not delay the Member's return to the Group home upon discharge from the hospital or crisis facility.
12. Qualified Vendors shall assist with the petition for Court Ordered Evaluation (COE) or Court Ordered Treatment (COT) upon witnessing an event that impacts the safety of the Member or others, when necessary in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520.
13. Qualified Vendors shall continue to provide support to the Member until the petition is accepted by the court and the Member is admitted to a facility for COE or COT.
14. If the petition for COE or COT is not accepted by the court, the Qualified Vendor shall transport the Member back to the Group Home.
15. The Qualified Vendor operating a Group Home in which Members reside shall notify the Division's Statewide Residential Network team within 24 hours if a Member:
    a. Is unable to return to the Group Home due to the Member having been served an Order of Protection; or

b. Requires emergency relocation to an alternative Group Home.

16. Qualified Vendors who have service authorizations for Members served with an Order of Protection shall continue to serve those Members as allowed for in 6 A.A.C. 6 Article 21.
17. Qualified Vendors shall maintain an after business hours contact and provide the after business hours contact information to the Division.
18. The Qualified Vendor operating a Group Home in which Members reside shall not restrict a Member's ability to access their community and common areas within the Group Home environment unless the restriction is approved in the Member's Behavior Plan.
19. Qualified Vendors operating a Group Home in which Members reside shall maintain at least three days worth of meals and snacks based on:
    a. The menu for each Group Home; and
    b. Special dietary needs.

20. Qualified Vendors operating a Group Home in which Members reside shall participate in Member meetings as outlined in Provider Manual Chapter 2.
21. Qualified Vendors providing Group Home services shall obtain and maintain the following records of Members who reside in the Group Home:
    a. Vital information documentation
        i. The name, address, and telephone numbers of the health care provider for each Member;
        ii. The name and telephone numbers of the health plan and insurance carrier for each resident and the process for authorization of health care for each Member;
        iii. Guardianship status for each Member, if applicable;
        iv. The name and telephone number of the Responsible Person;
        v. The person to be contacted in case of emergency for each Member;
        vi. Member funds ledger;

vii. Member's Group Home attendance records;

viii. Member's behavioral health documentation:

(a) Pre-move Behavior Plan;

(b) Post-move Behavior Plan; and

(c) Data collected from behavioral observations from the last 30 days.

b. Documentation of individualized needs

i. Completed Pre-service Provider Orientation (DDD-097A) form;

ii. Nutritional needs or special diets with parameters;

iii. Special fluid intake needs;

iv. Prescriptions for dietary needs or holistic medication;

v. Seizure activity information:

(a) Type and characteristics;

(b) Frequency and duration;

(c) Instructions for staff response; and

(d) Records of seizure activity.

vi. Adaptive equipment, protective devices, and facility adaptations;

vii. Required medical monitoring, including blood glucose testing, blood pressure checks, and lab work;

viii. Reference to the Behavior Plan or Planning Document if health care related issues are addressed;

ix. Special instructions for carrying, lifting, positioning, bathing, feeding, or other aspects of personal care;

x. Any known allergy to food, medication, bite or stings, or pollen and steps to be taken when an allergic reaction occurs; and

xi. Other individualized healthcare routines.

c. Complete medical history

i. Physical examination;

ii. Immunization records;

iii. Tuberculosis screening;

iv. Hepatitis B screening;

v. Type of developmental disability;

vi. Medication history;

vii. History of allergies;

viii. Dental history;

ix. Seizure history;

x. Developmental history; and

xi. Family medical history.

d. Medications

i. Copies of prescriptions or documentation of any verbal or written medical orders from a medical practitioner;

ii. Copies of the medication list provided upon discharge from an inpatient or skilled nursing facility;

iii. A current medication log for each Member with the following information:

(a) List of all prescription and nonprescription medications administered to a Member by or under the supervision of a direct care staff;

(b) The name of the Member who received the medication;

(c) The name of the medication;

(d) The medication dosage;

(e) The date and time of administration;

(f) The route of administration;

(g) Special instructions for administration of the medication; and

(h) Signature and initials of the direct care staff who administered or supervised the administration of the medication.

22. The Qualified Vendor providing Group Home service shall verify that the Member's medication log matches with:

    a. Current prescriptions;

    b. Current medical orders; and

    c. Discharge instructions upon discharge from a hospital or facility.

23. The Qualified Vendor providing Group Home service shall notify the Member's prescribing practitioner if any discrepancies are identified between prescriptions, medical orders, discharge instructions, or the medication log.

24. The Qualified Vendor providing Group Home service shall update the Member's medication log upon changes to the prescriptions or non-prescription orders from a medical practitioner.

B. BEHAVIORAL-SUPPORTED GROUP HOME (BSGH) ADDITIONAL REQUIREMENTS

1. Qualified Vendors operating a BSGH shall:
   a. Accept any Member referred by the Division; and
   b. Provide BSGH service for the referred Member.
2. The Qualified Vendor providing BSGH services shall, within 45 days of the Member's move-in to the BSGH, submit a Behavior Plan to:
   a. The Division's Behavioral Health Administration; and
   b. The Program Review Committee.
3. The Qualified Vendor providing BSGH services shall provide a minimum of ten hours of Clinical Oversight each week per BSGH setting, with a minimum of 50% of the hours provided onsite in the BSGH.

4. The Qualified Vendor providing BSGH service shall submit the Clinical Oversight Standard Agenda form to the Division two business days prior to the Clinical Oversight Meeting.
5. The Qualified Vendor providing BSGH service shall participate in Clinical Oversight Meetings.
6. The Qualified Vendor providing BSGH service shall ensure the following staff attend Clinical Oversight Meetings at minimum:
    a. The Behavioral Health Professional (BHP) employed by the Qualified Vendor; and
    b. A Qualified Vendor representative.
7. The Qualified Vendor providing BSGH service shall require the following when a Member transitions from the BSGH to a new setting:
    a. Current leadership, house supervisor, and BHP to tour the potential receiving setting at the request of the Responsible Person.
    b. The receiving Qualified Vendor and Planning Team, with input from both the BSGH and Division’s clinician, shall

develop a transition plan that includes the following, but is not limited to:

i. Member visit(s) to the new setting;

ii. The Member being observed by the receiving setting staff and DSPs;

iii. Training of staff and DSPs at the new setting by the BSGH; and

iv. Documenting the required training of staff and DSPs at the new setting on the Behavior Plan.

v. Training of Employment Services or Day Program staff, as applicable.

vi. Using the Residential Pre-Move Checklist for developing the transition plan.

c. BSGH clinical staff, with the Responsible Person's agreement, shall provide Clinical Oversight and support to the Member and the receiving Qualified Vendor for up to two months after the Member moves in as determined by the transition plan.

d. The BSGH clinical staff shall:

i. Participate in all transition and post transition meetings (i.e. medication reviews, Planning Document, etc.) while providing the agreed upon Clinical Oversight as outlined in the transition plan;

ii. Document all transition activities as outlined in the Member's transition plan; and

iii. Provide documentation on transition activities during all transition and post transition meetings.

e. The existing Qualified Vendor shall consult with the new Qualified Vendor to update the Member's Behavior Plan.

C. EMERGENCY RECEIVING HOME ADDITIONAL REQUIREMENTS

1. The Division may change the designation of the Emergency Receiving Home to a standard Group Home, if the Division deems it necessary.
2. The Qualified Vendor providing Emergency Receiving Home services shall accept any emergency Member referrals from the Division.

3. The Qualified Vendor shall ensure all Emergency Receiving Homes operated by the Qualified Vendor in which Members reside:
    a. Have sufficient staff immediately available to support the Member; and
    b. All DSPs have Prevention & Support training.
4. Qualified Vendors providing Emergency Receiving Home services shall adhere to the requirements in Section (A). of this policy.
5. The Qualified Vendor shall ensure all Emergency Receiving Homes operated by the Qualified Vendor in which Members reside are fully furnished, including bedrooms.

D. NURSING SUPPORTED GROUP HOMES (NSGHs) ADDITIONAL REQUIREMENTS

1. Qualified Vendors operating a NSGH in which Members reside shall submit a monthly census of the NSGH no later than the last day of the reporting month.
    a. The Qualified Vendor operating a NSGH shall submit the census through secure email to DDDResidentialunit@azdes.gov; and

b. The Qualified Vendor operating a NSGH shall notify the Division of all changes in Member moves, including internal moves or external moves within two business days.

2. The Qualified Vendor operating a NSGH in which Members reside may provide Nesting when requested by the Division's Health Care Services Department.
3. Qualified Vendors who operate a NSGH and provide Nesting shall develop, implement, and submit Nesting policies and checklists for review and approval by the Division's Network and Health Care Services Department.
4. Qualified Vendors who operate a NSGH shall ensure that the types and amount of nurses and other direct care workers as required by the Acuity Plan are present in the NSGH.

57 THIRD PARTY LIABILITY WAIVER REQUESTS

REVISION DATE: 10/25/2023, 9/7/2022, 4/25/2018
EFFECTIVE DATE: August 5, 2016
REFERENCES: 42 C.F.R. § 433.136; 42 C.F.R. § 433.138; 42 C.F.R. § 433.139; Deficit Reduction Act (DRA) of 2005; A.R.S. § 36-2903; A.R.S. § 36-2904; A.R.S. § 36-2923; A.R.S. § 36-596; A.R.S. § 36 Chapter 5.1; A.A.C. R6-6-1303; A.A.C. R6-6-2101; A.A.C. R9-22-1001; A.A.C. R9-22-1002; A.A.C. R9-22-1003; ACOM 201; ACOM 416; ACOM 434; CMS 1500

PURPOSE

This policy establishes requirements for Qualified Vendors when coordinating benefits and requesting Third Party Liability waivers for therapy and nursing services claims.

DEFINITIONS

1. "Coordination of Benefits" or "COB" means the activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
2. "Cost Avoidance" means the process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Division.
3. "Explanation of Benefits" or "EOB" means a document that states the Third Party insurance company's potential liability

for a claim that arises out of a contract of insurance. An EOB indicates how the payment was calculated and any reasons for non-payment.

4. "Qualified Vendor" or "QV" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Division.
5. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan as defined in 42 C.F.R. § 433.136.
6. "Third Party Liability" or "TPL" means the legal obligation of the third parties (e.g. certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

POLICY

A. QUALIFIED VENDOR TPL RESPONSIBILITIES

1. The QV shall coordinate benefits with Third Parties to ensure

costs for services otherwise payable by the Division are Cost Avoided or recovered from a liable Third Party.

2. The QV shall create appropriate methodologies and processes for obtaining documentation and payment from Third Parties, as required by the Division, to include, but not limited to:
   a. Resubmitting claims,
   b. Making follow-up phone calls, and
   c. Submitting additional requested information.
3. The QV shall bill the TPL(s), including High Deductible Health Plans that are associated with Health Savings Accounts (HSAs), before submitting claims to the Division.
4. The QV shall report to TPLBenefits@azdes.gov any updates to the member-specific TPL information within ten (10) business days of learning of the new information.
5. If a QV has been paid by the Division and subsequently receives reimbursement from a TPL, the QV shall submit a claim correction or claim reversal and report the TPL payment to the Division.
6. When a QV receives payment from a TPL in an amount that meets or exceeds the published rate, the QV shall report the

provision of service on the claim document indicating no amount due from the Division.

7. When a QV receives payment from a TPL in an amount that is lower than the published rate, the QV shall report the provision of service on the claim document up to the Division's contracted rate. The QV shall bill the Division for the difference between the TPL paid amount and the Division's contracted rate.

B. CLAIMS AND EXPLANATION OF BENEFITS

1. Prior to submitting a claim to the Division, the QV shall obtain an EOB that indicates denial of the claim from the member's TPL. If the TPL has not adjudicated the claim within six months, the QV shall submit the claim to the Division to preserve timely filing.
2. If the Division member is covered by more than one TPL, the QV shall obtain an EOB from each TPL.
3. When submitting a claim to the Division, the QV shall include the EOB and supporting documentation if necessary, verifying the rejection or non-payment of the claim by the TPL.
4. The QV shall ensure the billed service code reflected on the EOB corresponds to AHCCCS-approved Current Procedural

Terminology codes (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes.

C. APPLYING FOR A TPL WAIVER

1. Upon receiving an EOB with a denial of payment from the TPL, the QV shall request a TPL waiver from the Division to receive payment for the claim and to meet COB requirements.

2. The QV shall submit TPL waiver requests by email to TPLWaiver@azdes.gov; with the following required documents:
   a. A completed COBV Waiver Request form, and
   b. Each corresponding EOB.
   c. If the EOB does not contain the procedure codes (CPT/ HCPCS), the QV shall include the CMS 1500 form (if applicable).
   d. Other supporting documentation may be submitted with the COBV waiver request.

3. The Division shall deny TPL waiver requests if unapproved or incorrect procedure codes are submitted by the QV.

4. The Division shall deny TPL waiver requests when the EOB from the TPL is denying the claim for additional information or

corrected information.

5. The Division shall request additional information from the QV and or TPL carrier, if required.
6. The QV shall meet the criteria below to obtain a TPL waiver when billing for services covered under Medicare Part B:
   a. Be a certified Medicare provider.
   b. Submit a COBV Waiver Request and a Medicare Part B EOB.
7. The QV shall not submit a TPL waiver to the Division for billing pertaining to Medicare Parts A, C, and D.
8. The Division shall review all TPL waiver requests and provide the QV with an approval or denial status.
9. The QV may view approved waivers under "Waivers" in the Professional Billing System (PBS).
10. The Division shall email denied waivers to the QV.

D. THIRD PARTY LIABILITY EXCLUSIONS

The Division shall not require the QV to bill the following accounts, as they are not considered as liable Third Party resources:

1. Medical Savings Account (MSA);
2. Health Flex Spending Arrangement (FTA); and

3. Health Savings Account (HSA).

Chapter 58 MEDICATION MANAGEMENT SERVICES

REVISION DATES: 7/01/2020, 2/28/2019
EFFECTIVE DATE: March 29, 2013

Primary Care Provider (PCP) Medication Management Services

In addition to treating physical health conditions, the Division allows Primary Care Providers (PCPs) to treat behavioral health conditions within their scope of practice. Such treatment shall include but not be limited to substance use disorders, anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment. The Division includes the AHCCCS preferred drugs on the AdSS's drug list for the treatment of these disorders. The AdSS is responsible for these services both in the prospective and prior period coverage timeframes.

A. Medication-Assisted Treatment (MAT): The AdSS shall reimburse PCPs who are providing medication management of opioid use disorder (OUD) within their scope of practice. The PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the medication assisted treatment (MAT) model and coordinate care with the behavioral health provider. The AdSS shall include the AHCCCS preferred drugs on the AdSS drug list for the treatment of OUD.

B. Step Therapy: The AdSS may implement step therapy for behavioral health medications used for treating anxiety, depression, and ADHD disorders. The AdSS shall provide education and training for providers regarding the concept of step therapy. If the T/RBHA/behavioral health provider provides documentation to the AdSS that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the AdSS shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression, or ADHD. The AdSS shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

C. Tool Kits: Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AHCCCS Medical Policy Manual (AMPM). Refer to AMPM Appendix E, Childhood and Adolescent Behavioral Health Tool Kits and Appendix F, Behavioral Health Tool Kits. These tool kits are a resource only and may not apply to all patients and all clinical situations. The tool kits are not intended to replace clinical judgment. The AdSS shall ensure that PCPs who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized, clinical tools/evidence-based guidelines. The AdSS shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

CHAPTER 59 BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

REVISION DATE: 6/24/2022, 10/1/2021, 5/24/2021, 10/1/2018, 5/30/2018, 5/26/17 EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 CFR 433.135, 42 CFR 438.114; A.R.S. §§ 36-2904 and 2905.01; A.A.C. R9-22 A.A.C. R9-28 42 A.A.C. R9-22-1003; AHCCCS Contractor Operations Manual (ACOM) 423, ACOM 437

PURPOSE

The purpose of this policy is to provide guidance to Qualified Vendors/providers regarding the limited situations when ALTCS eligible members enrolled in one of the Division's Administrative Services Subcontractors (AdSSs) or Tribal Health Program (THP) has chosen to receive behavioral health services through a Tribal Regional Behavioral Health Authority (TRBHA), and the member is not receiving all of the physical and behavioral health services through one entity.

DEFINITIONS

1. "Acute Care Hospital" means a general hospital that provides surgical services and emergency services.
2. "DDD Tribal Health Program (THP)" means an acute care Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), Tribal Health

Programs operated under 638 or any other AHCCCS registered provider.

3. "Behavioral Health Diagnosis" means diagnoses listed in the Standard Service Set in AHCCCS Reference File (RF) 724.
4. "Behavioral Health Entity" means the TRBHA, with which the member is enrolled/assigned for the provision of and/or coordination of behavioral health services.
5. "Enrolled Entity" means the AdSS or THP with which the member is enrolled for the provision of physical health services.
6. "Primary Care Provider (PCP)" means an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP shall be an individual, not a group or association of persons, such as a clinic.

7. "Principal Diagnosis" means the condition established after study to be primarily responsible for occasioning the admission or care for the member, as indicated by the Principal Diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim line.

POLICY

A. Payment for Division covered behavioral health and physical health services is determined by the Principal Diagnosis appearing on a claim, except in specific circumstances as described below. This policy is not intended to address all scenarios involving payment responsibility. The Principal Diagnosis should not be confused with the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

B. GENERAL REQUIREMENTS REGARDING PAYMENT FOR PHYSICAL AND BEHAVIORAL HEALTH PAYMENTS

1. AHCCCS DFSM shall process payment of claims on behalf of THP when payment of physical and behavioral health services is a THP responsibility as the Enrolled Entity.
2. AHCCCS DFSM shall process payment of claims when payment of services is noted as a TRBHA responsibility as the Behavioral

Health Entity.

3. AHCCCS DFSM shall pay claims for physical and health services that are provided by an IHS or tribally owned and/or operated facility to Title XIX members.
4. Regardless of setting, if physical health services are listed on a claim with a behavioral health Principal Diagnosis, the AHCCCS DFSM (for members enrolled with a TRBHA) shall process payment of covered physical health services and behavioral health services.
5. Regardless of setting, if behavioral health services are listed on a claim with a principal diagnosis of physical health, the AdSS or AHCCCS DFSM (on behalf of THP) shall process payment of covered behavioral health services and physical health services.
6. Payment responsibility for professional services associated with an inpatient stay shall be based on the Principal Diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services may not necessarily be the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless

of the entity which authorized the inpatient stay.

7. The AdSS or AHCCCS DFSM (on behalf of THP) shall process payment for an emergency department facility claim of an acute care facility including triage and diagnostic tests, when there is no admission to the facility, regardless of the Principal Diagnosis on the facility claim. Payment responsibility for professional services associated with the emergency department visit shall be determined by the Principal Diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services may not necessarily be the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of notification of the emergency department visit.
8. The AdSS or AHCCCS DFSM (on behalf of THP) shall coordinate with the TRBHA Behavioral Health Entity when both physical and behavioral health services are rendered during an inpatient stay and the AdSS is notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations, determinations of medical necessity, and concurrent reviews.
9. All Division services shall be medically necessary, cost effective, and

federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712.60 et seq.

C. SPECIFIC CIRCUMSTANCES FOR PAYMENT RESPONSIBILITIES

1. The AdSS or AHCCCS DFSM (on behalf of THP), as the Enrolled Entity, shall process payment for the following:
    a. Services associated with a PCP visit for the diagnosis and treatment of behavioral health conditions within the PCP's scope of practice. Such treatment shall include but not be limited to substance use disorders, depression, anxiety, and/or ADHD. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment.
    b. Medication management services provided by the PCP while the member may simultaneously receive counseling and other medically necessary rehabilitative services from the TRBHA. The PCP shall not be required to be the member's assigned PCP, for purposes of medication management.
    c. Claims with behavioral health Principal Diagnoses that are related to communication disorders usually diagnosed in

infancy, childhood, or adolescence. These behavioral health conditions require services from non-behavioral health provider types such as speech therapists or other physical health providers, and are therefore considered physical health services.

d. Transportation for the member to the initial behavioral health appointment regardless of whether the Enrolled Entity or the Behavioral Health Entity scheduled that appointment.

e. Transportation for the member to the emergency department of an acute care hospital when the transport is emergent, including inter-facility transfers to the emergency department.

f. Occupational Therapy claims regardless of Principal Diagnosis.

g. Professional fees with a physical health Principal Diagnosis, regardless of setting.

h. Inpatient facility services to hospitalized members with a physical health Principal Diagnosis. Reimbursement shall not be related to the bed or floor where the member is placed.

i. Outpatient observation services with a physical health Principal Diagnosis.

2. AHCCCS DFSM (for members enrolled with a TRBHA), as the

Behavioral Health Entity, shall pay for the following:

a. Medically necessary transportation services for members enrolled with a TRBHA (emergent and non-emergent) when the diagnosis code on the claim is ICD-10 R68.89.

b. An inpatient claim with a behavioral health Principal Diagnosis. AHCCCS DFSM shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the AdSS or AHCCCS DFSM (on behalf of THP) authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis.

c. Inpatient facility services to hospitalized members with a behavioral health Principal Diagnosis. Reimbursement shall not be related to the bed or floor where the member is placed.

d. Professional fees with a behavioral health Principal Diagnosis, regardless of setting including, but not limited to, diagnosis and treatment of depression, anxiety, and/or opioid use disorder, and/or attention deficit hyperactive disorder except when depression, anxiety opioid use disorder and/or attention deficit hyperactive disorder treatment is provided by a PCP.

e. Outpatient observation services with a behavioral health Principal Diagnosis.

3. Payment of pre-petition screening and court ordered evaluation services is the fiscal responsibility of a county (refer to ACOM Policy 437). For payment responsibility for other court ordered services such as driving under the influence and domestic violence refer to ACOM Policy 423.

D. RBHA Contractors are responsible for the payment of crisis stabilization services for all individuals within their assigned GSA(s), including individuals in the Federal Emergency Services Program (FESP). Crisis services include telephone, community based mobile response, and facility-based stabilization (including observation and detox not to exceed 24 hours) along with payment for non-emergent medical transportation (NEMT) to a crisis stabilization provider and any associated covered services delivered by the crisis provider in these settings during the first 24 hours. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for all medically necessary services related to a crisis episode after the initial 24 hours covered by the RBHA Contractor (which may include follow up stabilization services). The AdSS or THP shall ensure timely follow up and

care coordination, whether the member received crisis services within or outside of the GSA served by the AdSS or THP. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for all emergent transportation provided during the initial 24 hours of a crisis episode. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for NEMT from a crisis service provider to another level of care, regardless of the timing within the crisis episode.

CHAPTER 60 NOTIFICATION TO QUALIFIED VENDORS

REVISION DATE: 11/24/2021
EFFECTIVE DATE: May 13, 2016

PURPOSE

To outline processes used to distribute information to the Division's Qualified Vendor Network.

DEFINITIONS

Material Change to Provider Network – Any change in composition of or payments to the Division's provider network that affects, or can reasonably be foreseen to affect, the Division's capacity and adequacy of services necessary to meet the performance and/or provider network standards as required by AHCCCS. Changes to provider network may include, but are not limited to:

1. A change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

2. A change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.

Material Change to Business Operations - Any change in overall operations that affects, or can reasonably be foreseen to affect, the Division's ability to meet the performance standards as required in its contract with AHCCCS including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or its provider network in a specific Geographic Service Area (GSA). Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review.

Material Event – An event that could prevent or impede the vendor's ability or legal authority to perform its duties under this Agreement, including but not limited to the duty to render services in a manner that protects the health and safety of DDD members.

Provider - Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services as specified in 42 CFR 457.10 and 42 CFR 438.2. This includes Service Providers as defined at ARS 36-551 also called Qualified Vendors.

POLICY

The Division provides information to the Qualified Vendor network on its webpage and through various electronic communications including email and newsletters, and through scheduled provider meetings. Qualified Vendors are responsible to ensure the Division's contracting system has updated contact information in order to receive the Division's notifications.

A. Material Changes/Material Events

1. The Division communicates to Qualified Vendors, any Material Change that may reasonably be foreseen to affect the quality or delivery of services provided to affected providers at least 30 days prior to the change.

2. Qualified Vendors are required to report to the Division any Material Event as required in the DES/DDD Standard Terms and Conditions for Qualified Vendors. The Qualified Vendor must notify the Division's Contract Administrator at DDDContractsmanager@azdes.gov within 24 hours of a material event.

B. Policy Changes

1. The Division notifies Qualified Vendors of Policy changes in advance of the change by posting all proposed new policies and major policy changes to its website for public comment. Qualified Vendors are responsible to review potential changes and provide comments. Final changes are communicated to Qualified Vendors through the Division's electronic notification and in provider meetings. Additionally, Qualified Vendors and their employees or subcontractors may sign up for automatic policy notification on the Division's website. Qualified Vendors are responsible to update their policies and procedures within 6 months of the final publication of the Division's policy change or sooner if outlined in a specific policy.

2. The Division notifies Qualified Vendors of AHCCCS Guidelines, Policy, and Manual Changes through electronic notification. Qualified Vendors are also encouraged to sign up for notification directly on the AHCCCS website.

C. Contract Notifications

The Division provides contract notifications for the following circumstances:

1. Exclusion from the Network: The Division provides applicants for Qualified Vendor Agreements notification in writing with the reason for declining any written request for inclusion in the network.

2. Contract Action: The Division provides written documentation of any progressive contract action, including termination actions. Qualified Vendors must develop plans and implement actions to come into compliance with contract requirements.

D. General Notifications

1. The Division provides notification and a schedule of provider meetings and documentation from past meetings on its website. Qualified Vendors are expected to attend provider meetings to receive updates and technical assistance regarding service delivery to Division members.

2. The Division provides information about Disease/Chronic Care Management on its website. Qualified Vendors should review and distribute information if pertinent to authorized members.

CHAPTER 61 HOME AND COMMUNITY BASED SERVICES (HCBS) CERTIFICATION AND PROVIDER ENROLLMENT

REVISION DATE: 11/4/2020, 8/21/2019, 06/20/2018

EFFECTIVE DATE: June 17, 2016

REFERENCES: A.R.S. § 36-594.01, 42 CFR 431.107

All providers of AHCCCS-covered Home and Community Based Services must be HCBS certified by the Division of Developmental Disabilities (Division). The Division's Office of Licensing, Certification, and Regulation (OLCR) assists vendors and providers with this process. HCBS Certification provides a uniform standard for worker qualifications and site safety. Home and Community Based Services allow members of the Division to receive services in their own home or community rather than in institutions or isolated settings.

The Division certifies Independent Providers, Specialty Contractors, Qualified Vendors and, effective 10/1/2019, DD Health Plan Providers.

- Independent Providers (IPs) are individuals that have an Independent Provider Agreement with the Division.
- Qualified Vendors (QVs) are agencies that have been awarded a Qualified Vendor Agreement from the Division.
- DD Health Plan providers are contracted by a Managed Care Organization (MCO) to provide HCBS services to Division members.
- Specialty Contract/AZEIP providers provide HCBS services to DD ALTCS eligible members through the Arizona Early Intervention Program.

HCBS Certification Requirements

The rules governing HCBS Certification are found in the Arizona Administrative Code (A.A.C.) R6-6-1501 et. seq. HCBS requirements vary depending on the employee type and type of service provided. HCBS requirements for direct service providers include, but are not limited to:

A. Possession of a valid Level One Fingerprint Clearance Card, except when exempted by A.R.S. § 36-594.01(D). If services are delivered in the private home of a direct care worker, all adult household members of the home must also have a Level One Fingerprint Clearance card.

B. Completion of a Criminal History Self-Disclosure affidavit (LCR-1034A).

C. Identification of three references.

D. Proof of age (providers must be at least 18 years old).

E. Submission of an application or resume attesting to the qualification or experience requirements specific to each service.

F. Orientation to member's needs.

G. Possession of Cardio-Pulmonary Resuscitation (CPR) certification.

H. Possession of First Aid certification (professionally licensed providers are exempt).

I. Completion of Article 9 training.

J. Submission to a Department of Child Safety Central Registry check.

K. Submission to an Adult Protective Services Registry Check.

L. Possession of a valid Driver License (if transporting members).

M. Possession of a valid auto registration and insurance if transporting members in a personal vehicle.

N. Completion of Prevention and Support (if required by the member's planning document).

O. Verification of professional licensure (if providing professionally licensed services).

If services are delivered in a setting owned, leased, or controlled by the provider, the setting must pass a safety inspection by the Division prior to use for service delivery. The Division will reinspect the setting every two years thereafter.

HCBS certified providers are required to maintain documentation attesting to compliance with HCBS requirements for all staff. The Division conducts a file audit at least every two years.

HCBS Certification for Independent Providers

Independent Providers apply for certification with the assistance of an Independent Provider Coordinator (IPC) assigned by the Division. The IPC provides required forms including an initial application and an applicant Statement of Understanding. The IPC also collects documentation attesting to compliance with all HCBS requirements.

Individuals with an Independent Provider Agreement must submit an initial application.

A. Include in the application packet:

1. Application for Initial HCBS Certification (LCR-1025A)

2. A copy of a Level One Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS), unless the applicant is exempted per A.R.S. § 36-594.01

3. A copy of the *Criminal History Self Disclosure Affidavit (LCR-1034A)*

4. Applicant Statement of Understanding (LCR-1064A)

5. Statement of Lawful Presence (LCR-1075A)

6. Three reference letters

7. Proof of successful completion of training for CPR, First Aid, and Article 9

B. All application documents must be provided to the IPC who will forward the documents to OLCR for processing.

The Independent Provider must contact the assigned IPC to initiate any amendments to the HCBS certificate. An amendment is needed for a change of address, contact information or name. An amendment is also needed for the addition or removal of services.

HCBS Certification for Qualified Vendors

Qualified Vendor Agencies or individuals with a Qualified Vendor Agreement must complete the HCBS Certification process online through the Division's Focus application. Once a QVA with the Division has been approved, the vendor should refer to OLCR Tracking Application Provider Reference Guide (DDD-OLCR-040-001_Provider) for instructions on how to submit an application for HCBS certification. An initial HCBS Certification application cannot be completed until a Qualified Vendor Agreement (QVA) with the Division has been approved.

The online HCBS Certification initial application includes:

A. An Application for Initial Certification (LCR-10-83A).

B. A staff roster of all direct care employees or contractors, including the CEO/President/Owner and authorized signatory as listed in the Qualified Vendor contract application. The roster must indicate compliance with all applicable HCBS training and background check requirements.

C. Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/President/Owner(s) of the agency and all contract signatories.

D. Proof of successful completion of training for CPR, First Aid, and Article 9 (if the owner/applicant is providing direct services).

Once the HCBS Certificate is issued, the vendor must keep the staff roster up to date. New employees must be added to the roster within 30 calendar days of hire. Employees must be removed from the roster within 30 calendar days of separation from employment. All other updates to the roster must be made within 30 calendar days of a change. The staff roster is reviewed by a certification specialist at each renewal. The roster is considered compliant when the OLCR Tracking Application indicates a 95% or higher compliance rating.

Qualified Vendors providing group home services must provide a copy of a current license or proof of inspection provided by the Arizona Department of Health Services to apply for an HCBS Certificate for each group home. The expiration date on a group home HCBS certificate is aligned with the expiration date on the agency's HCBS certificate.

For Qualified Vendors providing other types of site based HCBS services, a Life Safety inspection must be completed prior to using a site for services. A Life Safety Inspection must be completed every two years thereafter. It is the responsibility of the vendor to track inspection due dates and ensure service site information is up to date.

HCBS Certification for Providers Contracted with a Managed Care Organization (MCO)

DD Health Plan Providers who are contracted with both an MCO and DDD (as a Qualified Vendor) only need one HCBS certificate. These providers must complete the certification

process through the OLCR Tracking Application as outlined in this policy under HCBS Certification for Qualified Vendors.

DD Health Plan only providers must contact OLCR directly for certification instructions. Certification requires submitting an application form and documentation attesting to compliance with HCBS rules.

The required submission includes:

A. An Application for Initial HCBS Certification (LCR-1083A)

B. A copy of the Level One Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS) for the CEO/Owner

C. A copy of the Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/Owner

D. Three reference letters for the individual or agency

E. Proof of successful completion of training for CPR, First Aid, and Article 9 (if the owner/applicant is providing direct services)

F. A completed agency roster listing all staff providing direct services to members (LCR-1028A)

If services are delivered in a setting owned, leased, or controlled by the provider, a setting inspection must be completed by OLCR prior to services being delivered in this setting.

HCBS Certification for Specialty Contract/AZEIP Providers

Specialty Contract/AZEIP who are contracted with both an AzEIP and DDD (as a Qualified Vendor) only need one HCBS certificate. These providers must complete the certification process through the OLCR Tracking Application as outlined in this policy under HCBS Certification for Qualified Vendors.

Specialty Contract/AZEIP only Providers must contact OLCR directly for HCBS certification instructions. Certification requires an application form and documentation attesting to compliance with HCBS rules. The required submission includes:

1. Application for Initial HCBS Certification (LCR-1083A)

2. A copy of the Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS) for the CEO/Owner

3. A copy of the Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/Owner

4. Three reference letters for the individual or agency

5. Proof of successful completion of training for CPR, First Aid, and Article 9 if the owner/applicant is providing direct services

6. A completed agency roster listing all staff providing direct services to members (LCR-1028A)

If services are delivered in a setting owned, leased, or controlled by the provider, a setting inspection must be completed by OLCR prior to services being delivered in this setting.

Amending the HCBS Certificate

Any of the following changes requires an amendment to the certificate:

1. Address
2. Addition/deletion of services
3. Ownership
4. FEI
5. Contact information
6. Provider name

Qualified Vendors must submit an amendment request to the Qualified Vendor Agreement (QVA) in the contract application of the Division's Focus system. Once the contract amendment is approved, a certificate amendment is sent to in the OLCR Tracking Application.

Providers contracted with an MCO and AZEIP/Specialty Contractors must notify OLCR directly of the amendment request.

Independent providers must contact the Independent Provider Coordinator (IPC).

AHCCCS Enrollment

A. AHCCCS enrollment is mandatory. It is required for submission of encounter data to the AHCCCS Administration by the Division.

B. All Providers must work directly with AHCCCS for enrollment.

AHCCCS Mandates

AHCCCS mandates that all providers:

A. Comply with all federal, state, and local laws, rules, regulations, executive orders, and Division policies governing performance of duties under the Qualified Vendor or other contractual agreements.

B. Meet AHCCCS requirements for professional licensure, certification, or registration.

C. Complete all applicable enrollment forms.

Questions regarding HCBS certification may be directed to hcbscertification@azdes.gov.

CHAPTER 62 ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: September 22, 2021
REFERENCES: AMPM Policy 540, Electronic Visit Verification

PURPOSE

This Policy applies to DES DDD Qualified Vendors and establishes requirements regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. 1396(b)(l).

DEFINITIONS

Aggregator - A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.

Ahcccs Electronic Visit Verification (EVV) Vendor - The AHCCCS selected Statewide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

Alternate Electronic Visit Verification (EVV) System - Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected Statewide EVV vendor.

Designee - For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.

Direct Care Worker (DCW) - For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.

Electronic Visit Verification (EVV) - A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

Electronic Visit Verification (EVV) System Chapter 500 – Care Coordination Requirements - The AHCCCS procured system or an AHCCCS approved alternate EVV system.

Health Care Decision Maker - An individual who is authorized to make health care treatment decisions for the patient (member). As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231, or 36-3281.

Manual Edit - Any change to the original visit data. All edits shall include an appropriate audit trail.

Prior Authorization - For the purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a

temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

Qualified Vendor: For the purposes of this policy, means the same as Provider in AHCCCS AMPM 540.

Service Plan - A complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

POLICY

AHCCCS is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. 1396(b)(l). The Division and Qualified Vendors are required to utilize AHCCCS's single statewide EVV System for data collection. Qualified Vendors may use the EVV Vendor or choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS and the Division are using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that are mandated to use EVV can be found on the AHCCCS website and include but are not limited to Attendant Care, Habilitation Nursing, Homemaker, and Respite.

A. Service Verification

1. All Qualified Vendors who are subject to EVV must utilize the EVV Vendor or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.

3. If a member/Health Care Decision Maker is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/Health Care Decision Maker is required to sign a standardized attestation specified in Electronic Visit Verification (EVV) – Designee Attestation form (DDD-2102A), at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change decisions about verification delegation at any time by completing a new attestation. The Qualified Vendor shall keep the attestation on file, following the Divisions record retention requirements outlined in the Qualified vendor Agreement.

4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the DDD-2102A form prior to the delegation of service delivery verification responsibility.

5. Neither the Health Care Decision Maker nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or Health Care Decision Maker shall document on the DDD-2102A form.

B. Paper Timesheets

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.

2. Members for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.

3. Members electing not to use other visit verification modalities on the basis of moral or religious grounds.

4. Members with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Members who need to have their address and location information protected for a documented safety concern (i.e., witness protection or domestic violence victim or members in the Address Confidentiality Program as outlined in DES Policy VR-2.2-v1).

The member/Health Care Decision Maker and Qualified Vendor are required to sign a standardized attestation as specified in the Electronic Visit Verification – Paper Timesheet Attestation form (DDD-2101A) and utilize the standardized paper timesheet specified in the DDD Electronic Visit Verification Paper Timesheet form (DDD-2100A). The DDD-2101A form is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. The Division will review the records of the Qualified Vendor annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for Qualified Vendors to utilize their own paper timesheet as long as AHCCCS minimum data elements are captured.

The Qualified Vendor shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in Division of Developmental Disabilities Provider Manual, Chapter 12-Billing and Claim Submission are also met. The signature does not have to be recorded in the EVV System, but Qualified Vendors shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. EVV Modalities

1. The member/Health Care Decision Maker is able to choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. Qualified Vendors shall ensure that at least two different types of visit verification modalities are available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about the choice of data collection modality. The member/Health Care Decision Maker shall be permitted to change the modality at any time.

2. It is allowable for Qualified Vendors to allow DCWs to utilize personal devices such as a smartphone. If the Qualified Vendor elects this option, the Qualified Vendor is responsible to have a back-up plan for EVV if the device becomes inoperable.

3. If the Qualified Vendor chooses to allow for GPS tracking while the DCW is on the clock, the Qualified Vendor shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.

4. Members shall be afforded the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. Contingency/Back-Up Plan

Qualified Vendors are responsible for Contingency/Back-Up planning and shall use the standardized Contingency/Back-Up Plan as specified in Electric Visit Verification (EVV) Member Contingency/Back-Up Plan form (DDD-2099A) to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the Qualified Vendor is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Qualified Vendor with the member at least annually, and a current copy provided to the assigned Support Coordinator. In the event a visit is late or missed, the Qualified Vendor is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/Health Care Decision Maker can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference shall be applied based upon the service.

E. Reporting

The Division will monitor and analyze the Qualified Vendor's EVV data including the following:

1. Member access to care, including:

a. Late and missed visits and adherence to contingency planning preferences, and

b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AHCCCS AMPM Policy 1620-A (Initial Contact/Visit Standard), AMPM Policy 1620-D (Placement/Service Planning Standard), AMPM Policy 580 (Behavioral Health Referral and Intake Process), and AMPM Policy 310-B (Title XIX/XXI Behavioral Health Service Benefit).

2. Qualified Vendors Performance, including:

a. Unscheduled visits,

b. Manual Edits,

c. Device utilization,

d. EVV modality types in use,

e. Visits that follow the member's Contingency/Back-Up Plan, and

f. Monitoring of service hours authorized compared to service hours actually provided.

3. The Qualified Vendors shall self-monitor and analyze the following:

a. Performance, including:

i. Location discrepancies, and

ii. Visit exceptions.

b. Devices

i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider, as applicable.

c. Service Delivery

i. Monitor service hours authorized compared to service hours actually provided.

F. Qualified Vendor Requirements

1. Comply with annual EVV monitoring.

2. Collect and maintain records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation,

paper timesheet allowances, and contingency/back-up plans as specified in this Policy.

3. Counsel the member/Health Care Decision Maker on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.

4. Develop a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in or onsite caregivers; however, the Qualified Vendor shall facilitate a conversation with the member, their family, case managers (if applicable) to make a determination whether or not the exemption from the scheduling requirement is the best decision to support the member.

5. Ensure that all associated EVV Systems users are trained on the EVV System.

6. For providers using an Alternate EVV System, submit data timely as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Comply with member responsiveness including requirements that Qualified Vendors shall answer the phone 24/7 or return a phone call within 15 minutes to members or responsible persons who are reporting a missed or late visit.

8. For Qualified Vendors using the AHCCCS EVV Vendor, develop and implement policies to account for and ensure the return of devices issued by Qualified Vendors to DCWs.

9. Have at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.

10. Ensure any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.

11. Ensure that DCWs who utilize personal devices, such as a smartphone, have an alternate verification method or option if the device becomes inoperable.

12. Ensure that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g., landline telephone).

13. Contact the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements

for addendums to records. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

14. Document Manual Edits to visits within the system and/or maintaining hard copy documentation.

G. Qualified Vendor Attestation

Qualified Vendors shall complete an attestation verifying agreement to comply with the requirements of Electronic Visit Verification. This attestation shall be incorporated as a requirement of the Division's credentialing and recredentialing process.

H. After-Hours Telephone Survey

The Division conducts a telephone survey of the after-hours response of Qualified Vendors (Vendors) contracted to provide services subject to Electronic Visit Verification (EVV) to ensure calls made to the Vendor after business hours are answered immediately or returned within 15 minutes. In addition to the After-Hours Survey, the Division also monitors member grievance information about Vendor's after-hour responsiveness.

In order to ensure access to care for Division members, the Vendor's telephone system shall have a recorded message providing information to callers including the Vendor name and how to reach staff after hours. The message shall indicate to the caller the timeframes the caller can expect to receive a return phone call, not to exceed 15 minutes. The current after-hour contact information shall be maintained in the Division's CAS system.

Survey Process

A. The Division randomly selects the Vendor to participate in the After-Hours Telephone Survey and calls the Vendor, using the Vendor's after-hours telephone number(s) identified in Focus.

B. If the Vendor answers the call immediately or returns the call within 15 minutes, the Division documents the Vendor response and requires no additional survey-related action from the Vendor.

C. If the Vendor does not answer the call and does not return the call within 15 minutes:

1. Corrective Action Plan (CAP)

a. The Division will send a CAP letter to the Vendor, requiring the Vendor to submit a CAP to the Division within 14 calendar days from the date of the CAP letter.

b. If the Vendor does not submit a CAP to the Division within 14 calendar days from the date of the CAP letter, the Division shall send a second CAP letter to the Vendor, requiring that the

Vendor respond to the Division within five calendar days from the date of the second CAP letter.

c. If the Vendor does not respond to the Division within five calendar days from the date of the second CAP letter, the Division may follow progressive contractual action.

2. CAP Review and Verification

a. After review, the Division sends a letter to the Vendor, accepting or rejecting the CAP.

b. If the CAP is not accepted, the Division shall schedule a meeting with the Vendor and offer technical assistance to support the vendor's resubmission.

c. After Acceptance:

i. Division Network staff shall conduct three follow-up calls to the Vendor on different dates/times over three consecutive months.

ii. If the Vendor answers each after-hours follow-up phone call within 15 minutes or returns the call within 15 minutes, the Division staff shall send a letter to the Vendor indicating:

- Vendor is in compliance
- CAP is closed

iii. If the Vendor is not successful in answering the follow-up after-hours calls, the Division may follow progressive contractual action.

CHAPTER 63 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: May 8, 2019

REFERENCES: AHCCCS Contractor Operations Manual (ACOM) Policy 407; Division Operations Manual Policy 407

PURPOSE

The purpose of this policy is to establish the Qualified Vendors (QV) requirements to implement workforce development initiatives including:

1. Monitoring and collection of information about the workforce;
2. Collaborative planning of workforce development; and
3. Participation in Division directed initiatives, including surveys and technical assistance directed activities.

DEFINITIONS

1. "Competency" means a worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

2. "Competency Development" means a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs.
3. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
4. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
5. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and/or connecting workers to information.
6. "Workforce Development Alliance (WFDA)" means a name given to the WFD Administrators from each contractor that jointly plan and conduct WFD activities for a particular line of business.
7. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources that the Division implements including monitoring and

addressing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to provider organizations to strengthen their WFD programs.

8. "Workforce Development Plan (WFD-P)" means the Division's blueprint for ensuring the ongoing growth and development of the network's workforce.

A. GENERAL

1. Qualified Vendors shall work with the Division, AHCCCS, and Administrative Services Subcontractors (AdSS) to ensure members of the Division receive services from a workforce that is qualified, capable, and sufficiently staffed.
2. Qualified Vendors shall acquire, develop, and deploy a sufficiently staffed and qualified workforce that delivers services to members in an interpersonally, clinically, culturally, and technically effective manner.

B. WORKFORCE DEVELOPMENT PLAN

Qualified Vendors shall:

1. Develop and implement a Workforce Development (WFD) Plan that includes the following components:
    a. Workforce Profile;
    b. Workforce capacity assessment, development goals, and work plan; and
    c. Workforce capability/competency assessment, development goals, and work plan.
2. Annually review and update the plan, including an assessment of the progress toward the goals, maintain the plans on file, and submit to the Division upon request.

C. MONITOR WORKFORCE DEVELOPMENT ACTIVITIES

As part of the routine compliance monitoring process, the Qualified Vendor shall ensure:

1. The provider workforce has access to, and is in compliance with, all workforce training and competency requirements specified in federal and state law, Division policies, guidance documents, manuals, contracts and other Division generated plans;
2. There are processes for:
    a. Documenting training;

b. Verifying the qualifications, skills, and knowledge of personnel;

c. Retaining required training and competency transcripts and records; and

3. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

D. WORKFORCE DATA

Qualified Vendors shall collect and analyze required and ad hoc workforce data that:

1. Proactively identifies potential challenges and threats to the viability of the workforce;
2. Conducts analysis of the potential impact of the challenges and threats to the access to care for members;
3. Develops and implements interventions to prevent or mitigate threats to workforce viability; and
4. Develops indicators to measure and monitor workforce sustainability that include metrics focused on recruitment, retention, turnover, and time to hire.

SUPPLEMENTAL INFORMATION

1. AHCCCS and the Division generate policies that shape the worker, workforce, and workforce development practices.
2. The Division:
    a. Monitors the performance of the network;
    b. Collects information about the workplace;
    c. Develops plans to strengthen the workforce; and
    d. When needed, directly assists qualified vendors to develop and maintain a qualified, capable, and sufficiently capacitated workforce.
3. The Division offers training and resources to qualified vendors to assist professionals and family caregivers with managing stress and burnout as required by the Report of the Abuse & Neglect Prevention Task Force.

64 PREVENTING MEMBER ABUSE, NEGLECT AND EXPLOITATION

REVISION DATE: 3/22/2023, 9/21/2022
EFFECTIVE DATE: July 14, 2021
REFERENCES: State of Arizona Executive Order 2019-03 relating to Enhanced Protections for Individuals with Disabilities; AHCCCS Minimum Subcontract Provisions Number 29; A.R.S. §46-451 and 41-1492.10; CFR §165.2 (p); Division Operations Policy 6002-G.

PURPOSE

To establish posting of signage requirements and training requirements for Qualified Vendor staff and Division Members on identifying, reporting, and preventing Member Abuse, Neglect, and Exploitation.

SCOPE

This policy applies to Qualified Vendors and their staff, whether employed or contracted, who provide day treatment and residential services to Members of the Division of Developmental Disabilities (Division). Residential services include all group homes (group home, nursing supported group home, and community protection group home) and all developmental homes.

DEFINITIONS

1. “Abuse” means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily

function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

a. “Abuse (of a child)” means the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. As specified in A.R.S. §8-201(2), Abuse includes:

i. Inflicting or allowing sexual Abuse, sexual conduct with a minor, sexual assault, molestation of a child, commercial sexual Exploitation of a minor, sexual Exploitation of a minor, incest, or child sex trafficking as those acts are described in the Arizona Revised Statutes, A.R.S. Title 13, Chapter 14.

ii. Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in A.R.S. 13-3401.

iii. Unreasonable confinement of a child.

b. “Abuse (of a Vulnerable Adult)” means the intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual Abuse or sexual assault, and Emotional Abuse as specified in A.R.S.

§46-451(A)(1).

2. "Emotional Abuse" means a pattern of ridiculing or demeaning a Member; making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on a Member.

3. "Exploitation" means the illegal or improper use of a Member or the Member's resources for another's profit or advantage as specified in A.R.S. §46-451(A)(5).

4. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

5. "Neglect" means a pattern of conduct without the individual's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health as specified in A.R.S. §46-451(A)(7), and includes:

   a. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse.

   b. Sleeping on duty or abandoning workstation.

c. Intentional failure to carry out a prescribed treatment plan for a Member.

6. "Retaliation" means an adverse action taken against an individual for raising a concern about a possible violation or allegation of a potential act of Abuse, Neglect, or Exploitation; or participating in the investigation or other matters related to said act. Staff are expected to report concerns about possible violations or allegations of a potential act of Abuse, Neglect, or Exploitation as soon as they become aware of possible violations. Discipline or termination for staff failure to report or intervene is not considered Retaliation under this policy.
7. "Vulnerable Adult" means an individual who is 18 years of age or older and who is unable to protect himself/herself from Abuse, Neglect, or Exploitation by others because of a physical or mental impairment as specified in A.R.S. § 46-451. Vulnerable Adult includes an incapacitated person as specified in A.R.S. §14-5101.
8. "Whistleblower" means an individual, or two or more individuals acting jointly, who reports Abuse, Neglect, or Exploitation of Members to someone in a position to rectify the wrongdoing. Whistleblowers are protected from Retaliation under federal Whistleblower laws.

POLICY

The Division is committed to providing a safe environment for its most vulnerable Members. As part of that commitment the Division requires Qualified Vendors (vendors) of day treatment and residential settings to post signage in areas accessible to all staff, Division Members, families, and visitors, illustrating how to identify and report Member Abuse, Neglect, and Exploitation, anonymously or otherwise. The Division also requires vendors to provide training to staff and to offer training to Members.

A. SIGNAGE

1. Vendors are required to post the DES/DDD approved sign, "Everyone Has the Right to be Safe," in the service setting's telephone location and/or near posted emergency numbers. The signage is provided by the Division and can be found on the DES Website, in the Document Center, available in English and Spanish. There are two versions: One for individuals under 18 years of age (child) and one for individuals 18 years of age or older (adult). The vendor must post child or adult signage appropriate for the age of the Members receiving service in the setting.

2. Vendors are responsible for providing interpretation or translation of the signs into other non-prevalent languages at the request of the Member or responsible person.
3. Signage should be maintained in good condition and be easily readable.

B. STAFF TRAINING

1. Vendors shall provide staff training on identifying and reporting Member Abuse, Neglect, and Exploitation as follows:

    a. Newly hired staff shall receive instructor-led training within 90 days of the hire date, and

    b. All staff shall receive annual training which may be delivered through computer-based training.

    NOTE: Staff hired on or after the effective date of this policy must be trained within 90 days of their hire date. Staff hired before the effective date of this policy must be trained within 180 days of the effective date of this policy using instructor-led training.

2. Vendors may use the DES/DDD published curriculum, "Recognizing and Reporting Abuse, Neglect and Exploitation of Vulnerable Populations," available on the Division's training webpage, or use alternative curriculum with minimum components below:

   a. Definitions of Abuse (physical, emotional, programmatic), Neglect and Exploitation (including social media and photography).

   b. Recognizing the physical, behavioral, and environmental signs of maltreatment.

   c. List the common characteristics of perpetrators.

   d. Identify the disability, environmental and cultural factors that increase vulnerability and how to decrease them.

   e. Identify the disability, environmental and cultural factors that increase vulnerability and how to decrease them.

   f. Defining and modeling boundaries with personal space.

   g. Maintaining professional relationships when providing

intimate care.

h. Modeling how to say “no” to unwanted touching.

i. Rules for necessary touch and understanding how individuals may give permission.

j. List the methods for reporting maltreatment to protective agencies.

k. Identify key differences between police, Adult Protective Services, and Department of Child Safety.

l. Whistleblower protections for reporting and protection against Retaliation.

3. Conduct annual testing for staff responses to potential acts of Exploitive, Abusive, and Neglectful behavior to verify their understanding of the reporting requirements. This requirement can be met by establishing and reviewing case studies or scenarios of potential Exploitive, Abusive, and Neglectful behavior with staff and documenting their responses.

4. Maintain records of all staff training offered and delivered under

this policy. Using the following roster format:

a. Last Name

b. First name

c. DOB

d. Staff Fingerprint clearance number or Fingerprint application number

e. Vendor name

f. Vendor Assists ID

g. Trainer name

h. Date training completed

5. Issue a training certificate to each staff trained, signed, and dated by the trainer, and maintain a copy in vendor files.

C. MEMBER TRAINING

1. Vendors must offer Division Members training within six months of a new Member beginning day treatment or residential services, and annually thereafter, on the topic of identifying and reporting Member Abuse, Neglect, and Exploitation.

2. Vendors must use the “Awareness and Action” training materials provided by the Division on the Division’s training website.

Members are not required to take training offered but should be encouraged to do so.

3. Vendors must maintain records of all Member training offered and delivered under this policy and include the following:

   a. Member Name,

   b. Date training offered, and

   c. A roster of Members that received training, including:

      i. Last Name

      ii. First name

      iii. DOB

      iv. Member Assist ID

      v. Vendor Name

      vi. Vendor Assists ID

      vii. Trainer name

      viii. Date training completed

      ix. Time training completed

   d. Issue a training certificate to each Member trained, signed by

the trainer, and dated. Provide a copy to the Member and maintain a copy in vendor files.

4. Member training shall be instructor led.

5. Training shall be incorporated within routine service delivery.

   a. When Members are dually served in day treatment and residential services, the day treatment service vendor shall be responsible to offer and provide Member's training.

   b. Residential vendors shall offer and provide training to Members who do not participate in day treatment services.

Signature of Chief Medical Officer: Anthony Dekker (Mar 14, 2023 10:05 PDT)
Anthony Dekker, D.O.

CHAPTER 65 PROVIDING OUT OF STATE SERVICES

REVISION DATE: 2/7/2024, 6/24/2022
REVIEW DATE: 1/27/2023
EFFECTIVE DATE: March 3, 2021
REFERENCES: Division Operations Policy 4004-H, Division Medical Policy 1620-D, AdSS Medical Policy 450

PURPOSE

This policy provides guidance to Qualified Vendors and Providers for providing Medicaid services to Members who are eligible for Arizona Long Term Care System (ALTCS) and are Temporarily Out of State and need Medicaid services to support them out of state.

DEFINITIONS

1. "Home and Community-Based Services (HCBS)" means the same as in R6-6-1501.

2. "Medically Necessary Services" means those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability, and other adverse health conditions or their progression or to prolong life.

3. "Member" means the same as "Client" as defined in A.R.S. §

36-551.

4. "Out-of-Country" means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

5. "Out-of-State Services" means services provided to Members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency.

6. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

7. "Provider" means any individual or entity that is engaged in the

delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

8. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

9. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.

10. "Temporarily Out-of-State" means a Member is absent from Arizona and the member:

    a. Intends to return to Arizona when the reason for the absence is completed.

    b. Has not become a resident of another state.

i. For Members under the age of 18, residency is based on the custodial parent.

ii. Residency of another state includes, but is not limited to, applying for medical assistance, renting or buying a home, getting a job, and/or applying for a driver's license or identification in another state.

POLICY

A. DELIVERING OUT OF STATE SERVICES

1. All Qualified Vendors and Providers, prior to delivering Out of State Services, shall be:

   a. Enrolled with the Arizona Health Care Cost Containment System (AHCCCS), and

   b. Prior authorized by:

      i. The Division for HCBS, or

      ii. The Member's DDD Health Plan for physical and behavioral health services.

2. Qualified Vendors and Providers, shall ensure all service and

reporting requirements are met during the provision of Out of State Services.

3. The Qualified Vendor shall ensure nursing providers traveling Out of State are licensed in the state(s) they are traveling to with the Member.

4. The Qualified Vendor with the planning team, shall develop a plan for the Member's emergency medical care while delivering Out of State Services.

B. REQUESTING SERVICES OUT OF STATE

1. The Qualified Vendor, within one business day of a request for Out of State Services by a responsible person, shall:

   a. Notify the Member's Support Coordinator, and

   b. Inform the Responsible Person to notify the Member's Support Coordinator of the request for Out of State Services.

2. The Qualified Vendor shall receive approval from the Division prior to providing Out of State Services to the Member.

C. REQUIREMENTS FOR BEHAVIORAL-SUPPORTED GROUP HOME, GROUP HOME, AND DAILY SUPPORTED LIVING SERVICES

1. The Qualified Vendor shall submit a revised staffing schedule when additional staff are needed to support a Member traveling out of state.

2. The Qualified Vendor shall receive Division approval for the revised staffing schedule prior to the Member receiving Out of State Services.

D. OUT OF STATE SERVICES THAT ARE NOT COVERED

A Qualified Vendor or Provider shall not bill or be paid for Medicaid covered services when the Member is Out of Country.

E. SUPPLEMENTAL INFORMATION

The Division does not cover Medicaid services including emergency medical care and HCBS for a Member traveling Out of Country.

66 BEHAVIORAL HEALTH

EFFECTIVE DATE: June 24, 2022

REFERENCES: 42 C.F.R. § 438.102; A.R.S § 8-512.01; A.R.S. § 36-550; A.R.S.§ 36-551; A.R.S. Title 36, Chapter 5, Article 4 and 5; A.A.C. R6-6-807; AMPM 100; AMPM Chapter 200 Behavioral Health Practice Tools; AMPM 650; Behavior Supports Manual; AMPM 960; AdSS Medical Policies 310-B, 320-O, 320-P, 320-R, 320-S, 320-U, 320-V, 320-W, 320-X, 450, 541, 580, 960, 963, 964, 1020, 1040; AdSS Operations Policies 110, 415, 417, 446, 449

PURPOSE

The purpose of this policy is to clarify expected roles and responsibilities of Qualified Vendors (QVs) related to coordinating and supporting the implementation of behavioral health services, as well as to provide additional information regarding the System of Care.

DEFINITIONS

1. “Adult Recovery Team” (ART) means a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service

planning, and service delivery. At a minimum, the team consists of the member/responsible person, advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

2. “Child and Family Team” (CFT) means a group of individuals that includes, at a minimum, the child and their family/) Responsible Person., a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The

size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

3. "Serious Mental Illness" (SMI) means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.
4. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

POLICY

A. QV ROLES AND RESPONSIBILITIES RELATED TO BEHAVIORAL HEALTH SERVICES

While the Division delegates the delivery of behavioral health services to the Administrative Services Subcontracted health plans (AdSS), the Division's QVs play an integral role in supporting the delivery and coordination of behavioral health services. QV shall complete the

following activities to ensure members have access to coordinated and integrated services.

1. All QVs shall:
    a. Be knowledgeable of and support the System of Care and Guiding Principles outlined in AMPM 100.
    b. Play an integral role by providing input to the Planning Team and behavioral health providers regarding a member's behavioral health needs.
    c. Implement strategies to address behavioral concerns about the member, assist in developing behavior intervention programs, and coordinate with behavioral health programs to ensure proper review of medication treatment plans.
    d. Communicate with behavioral health providers and the Planning Team as needed to ensure coordination of care. Responsibilities include but are not limited to:
        i. Identify and communicate barriers to accessing behavioral health services.

ii. Communicate the progress, or lack of progress with achieving goals outlined in a member's Behavioral Plan or Functional Behavioral Assessment.

iii. Provide the Planning Team updates regarding changes with behavioral health needs and services.

iv. Share any concerns about behavioral health symptoms or changes with behavioral health needs.

v. Complete Incident Reporting as required. Refer to Division Operations Policy Chapter 6000 for details regarding Incident Reporting requirements.

vi. Respond via email or phone communications with behavioral health providers within 2 business days.

vii. Advise or advocate on behalf of a member. The QV shall comply with the requirements under 42 C.F.R. § 438.102 and the intergovernmental Agreement between the Division and AHCCCS. The Division may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is authorized

to receive services from the provider for the following:

1) The member's health status, medical care, or treatment option including any alternative treatment that may be self-administered.
2) Any information the member needs in order to decide among all relevant treatment options.
3) The risks, benefits, and consequences of treatment of no treatment.
4) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

e. Ensure staff participation in trainings and implement recommended behavioral strategies from behavioral health professionals, as outlined in a member's planning document.

f. Attend Child and Family Team (CFT) meetings or Adult Recovery Team (ART) meetings.

g. Implement Behavior Plans (BP)/Functional Behavioral Assessments (FBAs) as described in Behavior Supports Manual.

h. Ensure timely and complete behavioral data collection and submission. Refer to Provider Manual Chapter 35 for further details regarding progress reporting requirements.

2. In addition to the above, the following applies to residential QVs:

a. Notify the Division of all hospitalizations within twenty-four hours of admission, including admission to a behavioral health facility.

b. Participate in proactive discharge planning for any hospital or emergency department admissions.

c. Ensure members attend scheduled services, as outlined in a member's Planning Document.

d. Provide environmental and programmatic safeguards and structures that protect the community and treatment for member care as well as other members, neighbors, and the community from those behaviors that endanger the community and treatment of the member, other people, or

property, and/or interfere with the rights of others. The QV shall be responsible for assuring supervision of the member as defined in the Planning Document.

B. ADULT SYSTEM OF CARE - NINE GUIDING PRINCIPLES

The Adult System of Care (ASOC) is a continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health or substance use challenges. The ASOC is organized into a comprehensive network to create opportunities that foster rehabilitation addressing impairment, managing related symptoms, and improving health outcomes by:

1. Building meaningful partnerships with members served.
2. Addressing the member's cultural and linguistic needs, and
3. Assisting the member in identifying and achieving personal and recovery goals.

The following principles were developed to promote recovery in the adult behavioral health system. System development efforts, programs,

service provision, and stakeholder collaboration shall be guided by these Nine Guiding Principles:

1. RESPECT

   Respect is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.

2. INDIVIDUALS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS

   An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Individuals in recovery should be involved at every level of the system, from administration to service delivery.

3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS

An individual in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE

An individual in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE

An individual in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST

An individual in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. INDIVIDUALS IN RECOVERY DEFINE THEIR OWN SUCCESS

An individual in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Individuals in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES

An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. An individual in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY

An individual in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience.

C. CHILD SYSTEM OF CARE - 12 GUIDING PRINCIPLES

Arizona's Child and Family Team (CFT) practice model blends shared concepts of the 12 Arizona Principles with the 10 Principles of Wraparound: Family voice and choice, teambased, natural supports, collaboration, community based, culturally competent,

individualized, strengths based, unconditional, and outcome based. In CFT Practice, it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually for each child and family based on their needs and strengths.

One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family, contributes to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

Service delivery shall incorporate the Arizona Model in all aspects of service delivery to children and families at all levels of need/acuity as well as children with complex needs or who are determined to have a Serious Emotional Disturbance (SED).

ARIZONA VISION

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to

the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

12 GUIDING PRINCIPLES

1. COLLABORATION WITH THE CHILD AND FAMILY

Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. FUNCTIONAL OUTCOMES

Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. COLLABORATION WITH OTHERS

When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other individuals needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team: a. Develops a common assessment of the child's and family's strengths and needs, b. Develops an individualized service plan, c. Monitors implementation of the plan, and d. Makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES

Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. BEST PRACTICES

Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by Arizona Department of Health Services (ADHS) that incorporate evidence-based “best practice.” Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive

sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING

Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. TIMELINESS

Children identified as needing behavioral health services are assessed and served promptly.

8. SERVICES TAILORED TO THE CHILD AND FAMILY

The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. STABILITY

Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan

for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE

Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE

Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including

transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS

The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

D. COVERED BEHAVIORAL HEALTH SERVICES

The Division covers Title XIX/XXI behavioral health services for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing Title XIX/XXI behavioral health services to members are outlined in the Division Medical Policy Manual (DMPM) 310-B, including additional requirements for members that have chosen the DDD Tribal Health Program (THP) as their health plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to

services for THP members. See AdSS Medical Policy 310-B for responsibilities of the Division's Subcontracted Health Plans providing Title XIX/XXI behavioral health services.

Title XIX/XXI Behavioral Health Services Categories/Subcategories:

1. Treatment Services: Assessment, Evaluation (non-court ordered), Screening, Counseling, Therapy, Psychophysiological Therapy and Biofeedback.
2. Rehabilitation Services: Skills Training and Development, Psychosocial Rehabilitation Living Skills Training, Cognitive Rehabilitation, Health Promotion, Psychoeducational Services, Ongoing support to maintain employment services/Job Coaching, Pre-vocational services.
3. Medical Services: Medication, Laboratory, Radiology, Medical Imaging, Medical Management.
4. Support Services: Case Management, Respite, Home Care Training/Family Support, Self-Help/Peer Services (Peer and Recovery Support), Therapeutic Foster Care for Children, Adult Behavioral Health Therapeutic Home, Unskilled Respite Care,

Behavioral Health Day Programs, Community Psychiatric Supportive Treatment Programs.

5. Behavioral Health Residential Facility Services.
6. Behavior Analysis.
7. Crisis Intervention Services (delivered through the RBHA's): Telephonic Crisis Intervention, Mobile Crisis Team Intervention, Facility Based Crisis Interventions, Emergency and Non-Emergency Medical Transportation.
8. Inpatient Services: Hospital and Behavioral Health Inpatient Facility (BHIF).

E. BEHAVIORAL HEALTH ASSESSMENT AND REFERRAL

DDD ALTCS eligible members have access to covered behavioral health services for mental, emotional, and substance use disorders without the requirement of a referral. A member, responsible person, family member or care provider may make oral, written or electronic requests for behavioral health services at any time. To avoid duplication of referrals, the QV shall communicate with the Support Coordinator prior to making direct referrals. Refer to Division Medical Policy 1620-G for details Division Behavioral Health Referrals.

A referral may be made directly by the member, prospective member, responsible person, Primary Care Physician (PCP), the health plan, or another care provider, hospital, treat and refer provider, jail, court, probation, or parole office, school or other government or community agency as specified in A.R.S. § 8-512.01. Refer to AdSS Medical Policy 580, and AdSS Operations Policy 417, and 449 for information regarding timeline requirements in place to ensure members have timely access to behavioral health services.

F. BEHAVIOR PLANS AND PROGRAM REVIEW COMMITTEE

Refer to the Behavior Supports Manual for details related to the implementation of Behavior Plans and requirements related to Article 9.

THE FOLLOWING INFORMATION APPLIES TO THE AdSS AND THEIR NETWORK OF BEHAVIORAL HEALTH PROVIDERS. THIS DOES NOT APPLY DIRECTLY TO QVS, HOWEVER, INCLUDES INFORMATION THAT MAY BE HELPFUL TO ENSURE COORDINATION OF CARE.

G. DUTY TO WARN

Behavioral health providers have a duty to protect others against a member's potential danger to self and/or danger to others. When a

behavioral health provider determines, or under applicable professional standards, reasonably should have determined that a member poses a serious danger to self or others, the provider has a duty to take reasonable precautions to prevent harm and protect others against imminent danger of a member harming him/herself or others. Reasonable precautions include:

1. Communicating, when possible, the threat to all identifiable victims.

2. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides.

3. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate and in accordance with AdSS Medical Policy 320-U.

4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Behavioral health providers have immunity from liability when they perform duty to warn under A.R.S. § 36-517.02. Refer to AMPM 960, AdSS 960 or A.R.S. § 36-517.02 for further details.

H. HOUSING CRITERIA FOR INDIVIDUALS DETERMINED TO HAVE AN SMI

The AHCCCS Housing Programs (AHP) consists of the permanent supportive housing and supportive health programs. The majority of AHCCCS available housing funding is reserved for members with a designation of Serious Mental Illness (SMI), although limited housing is provided for some individuals without an SMI designation who are considered to have a General Mental Health and/or Substance Use Disorder (GMHSUD) need. For persons with GMHSUD needs, housing priority is focused on persons identified with increased service utilization including crisis or emergency services and/or services addressing complex chronic physical, developmental, or behavioral conditions. For a limited number of units within the program, eligibility is further based upon receipt of specific behavioral health services such as an Assertive Community Treatment (ACT) Team.

AHP is community-based permanent supportive housing where a member should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing in both scattered site units (Scattered Site Program) as well as for dedicated site-based units (Community Living Program). All subsidized rental units must meet minimum standards of health and safety, as determined by Federal Housing Quality Standards (FQS), and have a reasonable rent based on market standards. Housing subsidies are currently paid to the landlord directly on behalf of the member/household. Members are expected to pay up to 30% of their income toward their rent with the balance subsidized by the program. In addition to housing subsidies, AHP funding also provides for housing related supports and payment such as deposits, move-in assistance, eviction prevention, and damages related to member occupancy. AHP does not include any Behavioral Health Residential Facilities, Group Homes, or other licensed clinical residential settings.

Funds for these purposes are limited based on budget availability. Supportive services are critical to housing stability and the related

benefits of permanent supportive housing. AHCCCS and AHP promote a Housing First model based upon principles of permanent supportive housing provided by the Substance Abuse and Mental Health Service Administration (SAMHSA). Supportive services for members in AHCCCS subsidized housing are determined by their provider and generally provided through Medicaid and other reimbursable services supplied by the managed care health plans and their provider networks. The State allocation for AHP is for approximately 3,000 members throughout Arizona. Arizona's State Legislature allocates Non-Title XIX/XXI General Fund money to AHCCCS annually to provide permanent supportive housing.

I. OUTREACH, ENGAGEMENT AND RE-ENGAGEMENT FOR BEHAVIORAL HEALTH

Outreach includes activities designed to inform members of behavioral health services availability and to engage or refer those members who may need services. Outreach and engagement activities are essential elements of clinical practice. Behavioral health providers must reach out to vulnerable populations, establish an inviting and non-threatening environment, and reestablish contact with members who have become

temporarily disconnected from services. Refer to AdSS Medical Policy 1040 for more details.

J. PARTNERSHIP REQUIREMENTS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN AND CHILDREN AND ADULT BEHAVIORAL HEALTH SYSTEM

The Division recognizes the importance of the Parent/Family Support role as a viable component in the delivery of integrated services. Parent/Family Support Services may involve support activities including, but not limited to:

1. Assisting the family to adjust to the individual's needs.
2. Developing skills to effectively interact, and/or
3. Guide the individual's:
    a. Understanding of the causes and treatment of behavioral health issues.
    b. Understanding and effective utilization of the system, or planning long term care for the individual and the family.

Refer to AdSS Medical Policy 963

K. PEER SUPPORT/RECOVERY TRAINING, CERTIFICATION, AND CLINICAL SUPERVISION

Individuals with lived experiences of recovery are an integral part of the behavioral health workforce. Peer support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the member's disability (e.g. support groups, coaching, role modeling, and mentoring). These services shall only be provided by Peer and Recover Support Specialists who have completed training and certification and receive clinical supervision. Refer to ADSS Medical Policy 963 for details.

L. PRE-PETITION SCREENING, COURT ORDERED EVALUATIONS AND TREATMENT

Court-ordered treatment (COT) is the civil commitment process laid out in A.R.S. Title 36, Chapter 5, Article 4 and 5. It states that when there is a belief that, due to a person's mental disorder and their unwillingness to engage with treatment, they are:

1. Danger to self
2. Danger to others

3. Persistently or acutely disabled

4. Gravely disabled

More information about these screenings and court-ordered treatment can be found in the AdSS Medical Policy Manual 320-U.

Members may seek a voluntary evaluation at any screening agency available statewide. During the COE and COT process, members may agree to a voluntary evaluation. A voluntary evaluation occurs after a pre-petition screening is filed but before a COE is filed. It requires the person's informed consent.

Emergency Situations: When a member is a danger to themselves or others due to their inability or unwillingness to seek voluntary mental health treatment, they may apply for emergency evaluation and admission in person. If the screening agency approves the application, it issues a pick-up order to law enforcement in the region where the member is located, requesting the member be delivered to the screening agency for evaluation.

Non-Emergency Situation: When members are not a danger to themselves or others but could be if their behavioral health issues

remain untreated, a non-emergent application can be filed through any of the following agencies.

M. REQUIREMENTS FOR BEHAVIORAL HEALTH PROVIDERS TO ASSIST INDIVIDUALS

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D “Extra Help with Medicare Prescription Drug Plan Costs” low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services. Refer to AMPM 650 for further details.

N. SECLUSION, RESTRAINT, AND EMERGENCY RESPONSE REPORTING REQUIREMENTS

All facilities are required to report seclusions, restraints and emergency responses. This applies to all state licensed behavioral health inpatient facilities, mental health agencies, out-of-state facilities and ADHS

treating members with ACC, DD and ALTCS EPD coverage. Types of restraint and seclusion include:

1. Chemical restraint: Pharmacological restraint that is not standard treatment. It helps manage the member's behavior or restrict their movement to lower the safety risk to themselves or others.
2. Mechanical restraint: Any device, article, or garment attached or next to a member's body that restricts the member's movement and is not easily removed. This lowers the safety risk to themselves or others.
3. Seclusion: Involuntary confinement in a room or an area from which the member cannot leave.

Refer to AdSS Medical Manual Policy 962 for details.

O. SERIOUS MENTAL ILLNESS (SMI) ELIGIBILITY DETERMINATION

Determination of SMI requires both the qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis. The licensed psychiatrist, psychologist, or NP of the determining entity (either the authorized AHCCCS designee or a TRBHA authorized to make the final determination) designates must make a final

determination about whether the person meets the SMI status eligibility requirements based on:

1. A face-to-face assessment or a qualified clinician's review of a face-to-face assessment (AMPM Policy 950), and

2. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

3. A member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four areas for most of the past 12 months. Or it must last for most of the past six months with an expected duration of at least six months:

    a. Inability to live in an independent or family setting without supervision.

    b. A risk of serious harm to self or others.

    c. Dysfunction in role performance.

    d. Risk of deterioration.

AHCCCS contracts with a specific determining entity to complete the SMI determinations. The determining entity will send the member a Notice of Decision letter by mail informing them of the final decision regarding their SMI determination. This letter will include information about their rights and how to appeal the decision. For more information, please refer to AdSS 320-P.

P. SMI GRIEVANCE AND APPEAL PROCESS

The SMI grievance process applies only to adults who have been determined to have a serious mental illness (SMI) and to all behavioral health services received by the member.

A grievance may be submitted if:

1. Rights have been violated.
2. Suspected abuse or mistreatment by staff of a provider.
3. Subjected to a dangerous, illegal, or inhuman treatment environment.

SMI grievances must be filed within 12 months of the rights violation occurring. The grievance must be filed with the agency responsible for

delivering the behavioral health services. Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS.

Q. SMI Determination Appeal Process

AHCCCS contracts with a Determining Entity to make a determination of SMI upon referral or request. Members seeking a determination of SMI and members who have been determined to have an SMI can appeal the result of the determination.

The determining entity will send a letter by mail to let the member know the final decision on their SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. If the determining entity finds the member is not eligible for SMI services, the letter will tell why. To file an appeal, members can call the determining entity or submit a written request to appeal the decision within 60 calendar days from the date on the Notice of Decision letter.

Refer to AdSS Operations Policy Manual 446 for additional details regarding the SMI grievance process.

R. SMI Treatment Appeal Process

Persons who have been determined to have a serious mental illness can also appeal parts of their treatment plan, including:

1. A decision regarding fees or waivers.
2. The assessment report, and recommended services in the service plan or individual treatment or discharge plan.
3. The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title 19/21 funds.
4. Capacity to make decisions, need for guardianship or other protective services, or need for special assistance.
5. A decision is made that the member is no longer eligible for SMI services.

6. A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

To file an appeal related to any SMI treatment plan/behavioral health services, the member/responsible person must call or send a letter to the agency/health plan that made the denial, discontinuance, suspension, or reduction in services.

The member/responsible person will receive written notice from the responsible agency that your appeal was received within 5 business days of the agency's receipt. An informal conference will be held with the responsible agency within 7 business days of filing the appeal.

The informal conference must happen at a time and place that is convenient for the member/responsible person. The member/responsible person has the right to have a designated representative of their choice assist them at the conference. The member/responsible person and any other participants will be informed of the time and location of the conference in writing at least two

working days before the conference. Individuals may participate in the conference over the telephone.

For an appeal that needs to be expedited, a written notice that the appeal was received will be sent to the member/responsible person within 1 business day of the responsible agency's receipt, and the informal conference must occur within 2 business days of filing the appeal.

If the appeal is resolved to satisfaction at the informal conference, the member/responsible person will receive a written notice that describes the reason for the appeal, the issues involved, the resolution achieved and the date that the resolution will be implemented.

If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS. The member/responsible person may waive the second level informal conference and proceed to a State Fair Hearing, however. If the second level informal conference with AHCCCS is waived, the responsible agency will assist the member/responsible person in filing a request for

State Fair Hearing at the conclusion of the health plan informal conference.

If there is no resolution of the appeal during the second informal conference with AHCCCS, the member/responsible person will be given information that will tell them how to get a State Fair Hearing. The Office of Grievance and Appeals at AHCCCS handles requests for State Fair Hearings upon the conclusion of second level informal conferences.

If an appeal is filed, any services already in place will continue, unless:

1. A qualified clinician decides that reducing or terminating services is best for you, or
2. You agree in writing to reducing or terminating services.

If the appeal is not decided in the member's favor, the responsible agency may require the member/responsible person to pay for the services received during the appeal process. If the member/responsible person still does not understand the Notice of Adverse Benefit Determination letter, they have the right to contact AHCCCS Medical Management at MedicalManagement@azahcccs.gov.

Persons determined to have a serious mental illness cannot appeal a decision to deny, suspend or terminate services that are no longer available due to a reduction in State funding.

Refer to AdSS Operations Manual Policy 944 for additional details regarding SMI appeals processes.

S. OTHER BEHAVIORAL HEALTH GRIEVANCE AND APPEAL PROCESSES

Members or their responsible person may refer to the DDD website or their DDD Health Plan websites for information about how to file grievances or appeals regarding behavioral health services that are not related to SMI determinations or SMI treatment.

T. AHCCCS DUGless PORTAL GUIDE

AHCCCS has developed a plan to help health care providers collect and report demographic and social determinants of health data. This plan reduces the number of data points care providers must report. It involves using: 1. Alternative data sources. AHCCCS has identified

current demographic elements in other AHCCCS data systems and other source agreements. 2. Social Determinants of Health ICD-10 Diagnosis codes. These diagnosis codes reported on claim submissions began April 1, 2018. 3. Demographic Portal. For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinate diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by care providers to collect applicable identified data elements for members. Both the provider organizations that historically provided data for the DUG as well as all care providers who typically provide these types of data will provide the required information through DUGless. For more information refer to the Demographics, Social Determinants and Outcomes page on the azahcccs.gov website.

U. BEHAVIORAL HEALTH BEST PRACTICE TOOLS

AHCCCS developed a set of Behavioral Health Best Practice Tools which have been converted to formal policies in the AMPM Chapter 200. The policies/tools set the expectations for the behavioral health providers. Many of the policies include information relevant to partner agencies,

such as QVs, who participate on the Child and Family Teams (CFTs) or Adult Recovery Teams (ARTs):

1. AMPM 210 Working with the Birth through Five Population.
2. AMPM 211 Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age.
3. AMPM 220 Child and Family Team.
4. AMPM 230 Support and Rehabilitation Services for Children, Adolescents, and Young Adults.
5. AMPM 240 Family Involvement in the Children's Behavioral Health System.
6. AMPM 250 Youth Involvement in the Children's Behavioral Health System.
7. AMPM 260 The Unique Behavioral HEalth Services - Needs of Children, Youth, and Families involved with DCS.
8. AMPM 270 Children's Out of Home Services.
9. AMPM 280 Transition to Adulthood.

Chapter 67 GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: May 18, 2022
REFERENCES: A.R.S. § 8-514.05(C), A.R.S. § 15-104, A.R.S. § 36-501 et seq, A.R.S. § 36-2272, A.A.C. R9-21-206.01, AHCCCS Medical Policy Manual (AMPM) Policy 310-V, and AMPM Policy 320-Q.

PURPOSE

The purpose of this policy is to outline the requirements for reviewing and obtaining General and Informed Consent for members receiving physical and/or behavioral health services, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

DEFINITIONS

1. "General Consent" means a one-time agreement that shall be obtained from a member or the member's responsible person to receive certain services, including but not limited to behavioral health services, that is usually obtained during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services.
2. "Informed Consent" means an agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by a member or the member's responsible person with no minimization of known

dangers of any procedures.

POLICY

A. MEMBER RIGHTS

1. Each member has the right to participate in decisions regarding his or her physical and/or behavioral health care, including the right to refuse treatment.
2. Members seeking physical or behavioral health services shall be made aware of the service options and alternatives available to them, as well as specific risks and benefits associated with these services in order to be able to agree to these services.

B. GENERAL CONSENT

1. Unless otherwise provided by law, General Consent shall be obtained before any services and/or treatment are provided. Verification of a member's enrollment does not require consent.
2. Providers treating members in an emergency are not required to obtain General Consent prior to the provision of emergency services. Providers treating members pursuant to court order shall obtain consent, as specified in A.R.S. Title 36, Chapter 5.

C. INFORMED CONSENT

1. A higher level of consent may be required for provision of specific behavioral or physical health services or for services provided to

vulnerable members. These requirements can be found in AMPM Policy 320-Q.

2. Providers of behavioral health services shall gain Informed Consent in a variety of specific circumstances for members with a Seriously Mentally Ill (SMI) designation. These requirements can be found in A.A.C. R9-21-206.01.

CHAPTER 68 ADVANCE DIRECTIVES

EFFECTIVE DATE: June 15, 2022
REFERENCES: 42 CFR 489.102; 42 U.S.C. § 1396(a)(57); A.R.S. § 36-3231; AHCCCS Medical Policy Manual (AMPM) policy 640

PURPOSE

The purpose of the policy is to ensure processes are in place for hospitals, nursing facilities, hospice providers, residential service providers, and home health care or personal care services to comply with Federal and State laws regarding Advance Directives for Adult Members. [42 U.S.C. §1396(a)(57)].

DEFINITIONS

1. "Adult Member" means a member aged 18 and over.
2. "Advance Directive" means a document by which an individual makes provision for health care decisions in the event that, in the future, the individual becomes unable to make those decisions.
3. "Conscientious Objections" means refusal to perform a legal role or responsibility because of moral or other personal beliefs, including practitioners providing or not providing certain care or

treatment to their patients based on reasons of morality or conscience.

POLICY

A. Members have the right to have information provided to them about the importance of Advance Directives including their rights to establish and rescind Directives at any time. At a minimum, providers shall comply with the following:

1. Maintain written policies for Adult Members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an Advance Directive;
2. Provide written information to Adult Members regarding the provider's policies concerning Advance Directives, including any Conscientious Objections;
3. Document in the member's record whether or not the Adult Member has been provided the information, and whether an Advance Directive has been executed;
4. Prevent discrimination against a member because of the

member's decision to execute or not execute an Advance Directive, and not place conditions on the provision of care to the member, because of the member's decision to execute or not execute an Advance Directive;

5. Provide education to staff on issues concerning Advance Directives including notification to staff who provide home health care or personal care services such as attendant care, respite, and nursing if any Advance Directives are executed by members to whom they are assigned to provide services; and
6. Ensure alternative Home and Community Based Services (HCBS) setting staff have immediate access to Advance Directive documents to provide to first responder requests.

B. Adult Member, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. § 36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:

1. The member's rights, regarding Advance Directives under Arizona state law.
2. The organization's policies respecting the implementation of

those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

3. A description of the applicable state law and information regarding the implementation of these rights.
4. The member's right to file complaints with Arizona Department of Health Services, Division of Licensing Services, and
5. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. This statement, at a minimum, shall:
    a. Clarify institution-wide Conscientious Objections and those of individual physicians,
    b. Identify state legal authority permitting such objections, and
    c. Describe the range of medical conditions or procedures affected by the conscience objection.

C. The provider is not relieved of its obligation to provide the above information to the member once the member is no longer

incapacitated or unable to receive such information. The provider shall have follow-up procedures in place to provide the information to the member directly at the appropriate time.

D. The above information shall also be provided to a member upon each admission to a hospital or nursing facility and each time the member comes under the care of a home health agency, hospice, or personal care provider. [42 U.S.C. § 1396a(w)(2)]

E. Providers shall provide a copy of a member's executed Advance Directive or documentation of refusal to the member's Primary Care Provider (PCP) for inclusion in the member's medical record, and provide education to staff on issues concerning Advance Directives.

69 CARE COORDINATION

EFFECTIVE DATE: June 15, 2022
REFERENCES: 20 U.S.C.§ 1400; A.R.S. § 13-3620; A.R.S. § 46-454; A.R.S. §15-765; AHCCCS Contract; AMPM 541; AMPM 1021; AMPM 1022; AMPM 1610; AMPM 710; AMPM 580; ACOM 416; ACOM 417; ACOM 449

PURPOSE

The purpose of this document is to provide a high-level overview of care coordination for Division of Developmental Disabilities (Division) members. It applies to all DDD providers.

DEFINITIONS

1. "Care Management" is a group of activities performed to identify and manage clinical intervention or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.
2. "Planning Document" means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP) or a Person-Centered Service Plan (PCSP).

3. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

A. OVERVIEW

The Division uses an integrated model and person-centered approach to meet the service and support needs for ALTCS eligible members. The Support Coordinator shall coordinate the physical and behavioral health services and Home and Community Based Services (HCBS) for Arizona Long term Care (ALTCS) eligible members enrolled with the Division as well as coordinate with other entities providing services and supports as outlined in this policy.

The Division has mechanisms and processes to identify barriers to timely services for members served by an AHCCCS health plan and/or other providers or entities and works collaboratively to remove barriers to care and to resolve concerns. The Division's Support Coordinator shall ensure that appropriate authorizations to release information are obtained prior to releasing information to other entities or providers. As mandatory reporters, Division staff shall make reports to DCS and APS as required per A.R.S. § 13-3620 and A.R.S. § 46-454.

B. CARE MANAGEMENT

For DDD members who have chosen a subcontracted health plan, the Division collaborates with the DDD Health Plan Care Managers to ensure member's biopsychosocial needs are met by early identification of health risk factors and special health care needs. DDD members who have chosen the Tribal Health Program (THP) receive Care Management from Division staff. Care Management is a team-based, outcome-driven program that identifies members with high and/or complex needs and ensures there is no duplication and over/under utilization of services. Members are assigned to the Care Management program to learn how to better manage their illnesses and meet their health care needs. For additional information regarding the Care Management program, refer to AMPM 1021.

C. DEPARTMENT OF CHILD SAFETY (DCS)

The Division collaborates with DCS to coordinate services for children in the care and custody of DCS or with family involvement with DCS. Children who are eligible for ALTCS shall receive physical and behavioral health services from a DDD subcontracted health plan. DDD members who

are in the care and custody of DCS but not eligible for ALTCS will receive these services from the Comprehensive Health Plan (CHP).

The Support Coordinator shall coordinate with the DCS caseworker to:

1. Ensure a behavioral health assessment is performed and identify behavioral health needs of the child, the child's parents and family, and provide necessary behavioral health services, including support services to caregivers;
2. As appropriate, engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
3. Coordinate behavioral health services to support family reunification and/or other permanency plans identified by DCS;
4. Coordinate activities and services that support the child and family case plans and monitor adherence to established timeframes in Division Operations Manual Policy 417, AdSS

Operations Manual Policy 449, and Division Medical Manual Policy 580.

5. Coordinate with providers rendering services to the member's family.

6. Coordinate with the Tribal Regional Behavioral Health Authority (TRBHA) for members receiving behavioral health services through a TRBHA.

D. COORDINATION OF CARE BETWEEN THE DIVISION AND SCHOOL SYSTEM

Although the Division is not financially responsible for educational services as specified in AMPM 710, coordination of care related to educational services is required to ensure members' needs are being met. For children over the age of 3 who receive special education services, the Support Coordinator shall include information and recommendations contained in the Individualized Education Plan (IEP) during the ongoing assessment and service planning process. The Support Coordinator shall:

1. Develop and maintain effective working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise for members they support.

2. Ensure that the member's Planning Document complements the education plan and reflects coordinated care for the member.

3. Coordinate with the Local Educational Agency (LEA) and the IEP team per A.R.S. §15-765 when a residential placement is needed for educational purposes to accomplish specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment.

E. ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1. Arizona Early Intervention Program (AZEIP)

AZEIP is Arizona's statewide interagency system of services and supports for families of infants and toddlers, birth to three years of age, with disabilities or delays. AzEIP is established by Part C

of the Individuals with Disabilities Education Act (IDEA), which provides eligible children and their families access to services to enhance the capacity of families and caregivers to support the child's development.

For children who are eligible for AZEIP and enrolled with the Division, the Support Coordinator shall:

a. Work collaboratively with Team Based Early Intervention Services (TBEIS) providers and the member's AHCCCS/ALTCS health plan to coordinate services and supports for these children and their families.
b. Ensure ALTCS/TSC requirements are met for Division members who are eligible for ALTCS or Targeted Support Coordination.
c. Coordinate with the LEA when the child reaches ages two years six months to plan for preschool transition.

2. Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR)

a. The Division and RSA/VR support Employment First policy, and practice, which means that employment should be the preferred day time activity for members of working age. For further details regarding Employment First Principles, Policy and Practice along with a description of models to support members in a variety of job-related settings, see Division Medical Policy 1240-E.

b. An Interagency Service Agreement (ISA) is in place between AHCCCS and RSA to provide specialty employment supports for members determined to have a Serious Mental Illness (SMI). Through this ISA, behavioral health agencies and RSA's Vocational Rehabilitation program (RSA/VR) work collaboratively with the ultimate goal of increasing the number of employed members who are successful and satisfied with their vocational roles.

3. Adult Protective Services (APS)

The Division collaborates and coordinates care for members involved with Adult Protective Services (APS)including, but not limited to, when APS is investigating a member incident involving abuse, neglect, or exploitation.

F. COURTS AND DEPARTMENT OF CORRECTIONS

1. The Division collaborates and coordinates care for members with physical or behavioral health needs and for members involved with:
    a. Arizona Department of Corrections (ADOC),
    b. Arizona Department of Juvenile Corrections (ADJC),
    c. Administrative Offices of the Court (AOC), and/or
    d. County Jails System.
2. The Division collaborates with courts or correctional agencies to coordinate member care as outlined in AMPM Policy 1022.

CHAPTER 70 QUALIFIED VENDOR INCIDENT REPORTING

EFFECTIVE DATE: May 10, 2023

REFERENCES: Division Medical Policies 960, 961; Division Operations Policy 416

PURPOSE

The purpose of this policy is to establish the requirements for qualified vendors and individual Providers to report Member Incidents, Accidents, Deaths, and Sentinel Events to the Division of Developmental Disabilities (Division) and Quality Management Unit. It also provides information on mandatory reporting requirements.

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a Member receiving behavioral health services or community services. Abuse also includes sexual misconduct, assault, molestation, incest, or

prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

2. "Community Complaint" means a complaint from the community that puts a Member or the community at risk of harm.
3. "Death" means expected (natural), unexpected (unnatural), or no Provider present.
4. "Death Expected" means Death from long-standing, progressive medical conditions, or age-related conditions, such as end-stage cancers, end-stage kidney or liver disease, end-stage Human Immunodeficiency Virus or Acquired Immunodeficiency Syndrome, end-stage Alzheimer or Parkinson diseases, severe congenital malformations.
5. "Death Unexpected" means Death from motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma Abuse, sudden Deaths from undiagnosed conditions or generic medical conditions that progress to rapid deterioration.
6. "Death No Provider Present" means Death of a Member living independently or with family and no Provider is being paid for service provision at the time of Death.

7. "Exploitation (Of a Vulnerable Adult)" means, as specified in A.R.S. §46-451(A)(5), the illegal or improper use of a Vulnerable Adult or their resources for another's profit or advantage.
8. "High Profile Case" means a case that attracts or is likely to attract attention from the public or media.
9. "Human Rights Violation" means a violation of a Member's rights, benefits, respect, and privileges guaranteed in the laws of the United States and the State of Arizona.
10. "Incident" means an unexpected event or occurrence that causes harm or has the potential to cause harm to a Member, or an indicator of risk to the health or welfare of the Member.
11. "Medication Error" means that one or more of the following has occurred:
    a. Member given the wrong medication,
    b. Member given the wrong medication dosage,
    c. Member given medication at the wrong time,
    d. Member not given medication at all,
    e. Member given medication wrong route, or
    f. Medication given to the wrong person.
12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

13. "Neglect (Of a Child)" means, as specified in A.R.S. §8-201, the inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care.
14. "Neglect (Of a Vulnerable Adult)" means, as specified in A.R.S. §46-451(A)(7), a pattern of conduct without the Member's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health.
15. "Planning Document" means a plan which is developed by the planning team, such as an Individualized Family Service Plan (IFSP) or Person-Centered Service Plan (PCSP).
16. "Provider" means an individual or entity that contracts with the Division or Arizona Health Care Cost Containment System for the provision of covered services to Members according to the provisions prescribed in A.R.S. §36-2901 or any subcontractor of a Provider delivering services pursuant to A.R.S. §36-2901.
17. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability

who is a member or an applicant for whom no guardian has been appointed as defined in A.R.S. §36-551.

18. "Sentinel Event" means an unexpected Incident involving Death, serious physical or psychological injury, or risk thereof.

19. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, including assessment or treatment in an emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

20. "Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(10), an individual who is eighteen years of age or older and who is unable to protect themselves from Abuse, Neglect, or Exploitation by others because of a physical or mental impairment.

POLICY

A. REPORTABLE INCIDENTS

Qualified Vendors and Providers shall report any of the following reportable Incidents:

1. Allegations of Abuse, Neglect, or Exploitation of a Member;
2. Death of a Member;
3. Delays or difficulty accessing care or services;
4. Healthcare acquired conditions and other Provider preventable

conditions;

5. Serious Injury;
6. Injury resulting from the use of a personal, physical, chemical or mechanical restraint, or seclusion;
7. Injury requiring medical care or treatment beyond first aid;
8. Medication error;
9. Missing Member;
10. Member suicide attempt;
11. Suspected or alleged criminal activity;
12. Emergency measures used by staff;
13. Environmental circumstances, such as inclement weather, loss of air conditioning, loss of water, loss of electricity, which pose a threat or may cause harm to a Member or requires a change in operations;
14. Health Insurance Portability and Accountability Act violation;
15. Allegations of Medicaid fraud, waste or abuse;
16. Missing or loss of Member funds or property less than $1,000;
17. Property damage less than $10,000;
18. Illicit drug use by staff or Member;
19. Allegations of Human Rights Violations;

20. High Profile Case or police involvement;
21. Community Complaint; or
22. Any other Incident that causes harm or has the potential to cause harm to a Member.

B. REPORTABLE SENTINEL EVENTS

Qualified Vendors and Providers shall report any of the following reportable Sentinel Events:

1. Death or Serious Injury associated with a missing Member;
2. Suicide, attempted suicide, or self-harm that results in Serious Injury;
3. Death or Serious Injury of a Member associated with a Medication Error;
4. Death or Serious Injury of a Member associated with a fall;
5. Stage 3, Stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting;
6. Death or Serious Injury of a Member associated with the use of a personal, physical, chemical or mechanical restraint, or seclusion;
7. Sexual Abuse or sexual assault of a Member during the provision of services;

8. Death or Serious Injury of a Member resulting from a physical assault that occurs during the provision of services;
9. Homicide committed or allegedly committed by a Member;
10. Missing or loss of Member funds or property over $1,000; or
11. Property damage over $10,000.

C. INCIDENT AND SENTINEL EVENT REPORTING

1. Qualified Vendors and Providers shall report Incidents to the Division no later than the next business day after the occurrence or notification of the occurrence, including submission of a detailed incident report to the Division's Quality Management Unit.
2. Qualified Vendors and Providers shall report Sentinel Events to the Division immediately at 602-375-1403 or 1-855-375-1403 and submit a detailed incident report to the Division's Quality Management Unit no later than the next business day after the occurrence. Phone lines are available 24 hours a day, weekdays, weekends, and holidays.
3. Qualified Vendors shall notify the following individuals or agencies as applicable:
   a. Member's Responsible Person unless otherwise specified in

the Member's Planning Document;

b. Assigned support coordinator; and

c. Law enforcement or other protective service agencies, as applicable, and document:

i. Name and title of the person submitting the report,

ii. Name of regulatory agency report was made,

iii. Name and title of regulatory agency taking the report,

iv. Date and time of the report, and

v. Tracking and report number from the regulatory agency, as applicable.

D. MANDATORY REPORTING

Qualified Vendors and independent Providers who have a reasonable basis to suspect that Abuse, Neglect, or Exploitation of a Member has occurred must report such information immediately to a peace officer or protective services agency.

Signature of Chief Medical Officer: Anthony Dekker (May 3, 2023 13:59 PDT)
Anthony Dekker, D.O.

Qualified Vendor Application and Directory System (QVADS)

Provider Instructions – Agency with Choice Option

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Document ID: DDD-QVADS-2885-001

Version 1.0

August 05, 2014

Division of Developmental Disabilities

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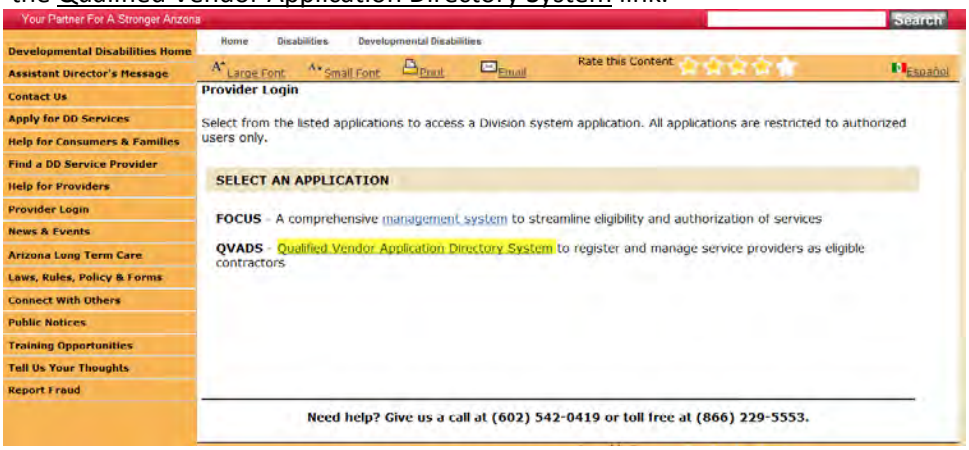
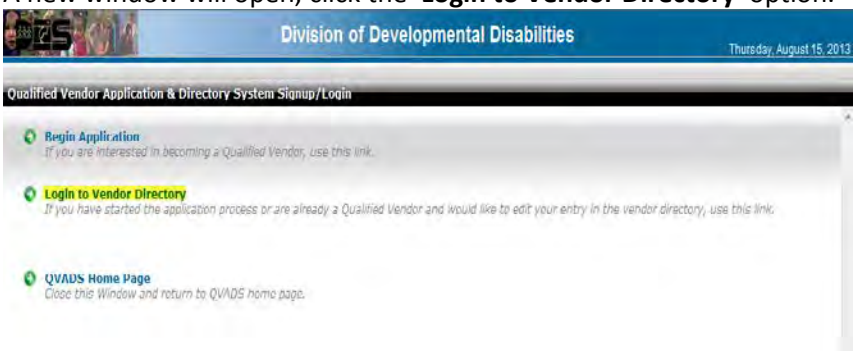
1 How to Login to QVADS

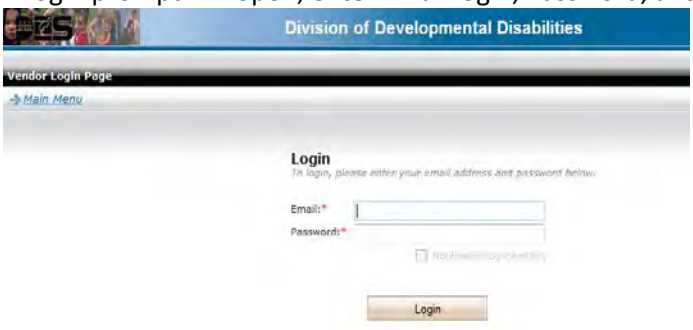
1. Login to QVADS by going to url https://www.azdes.gov/main.aspx?menu=96&id=2476 and click the Qualified Vendor Application Directory System link.



2. A new window will open; click the '**Login to Vendor Directory**' option.

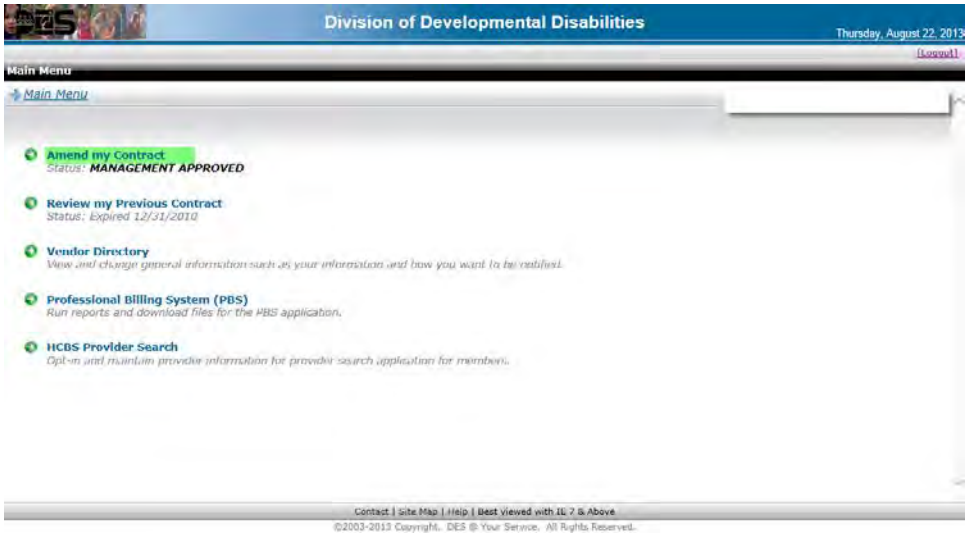


3. A login prompt will open; enter Email login, Password, and click [Login]

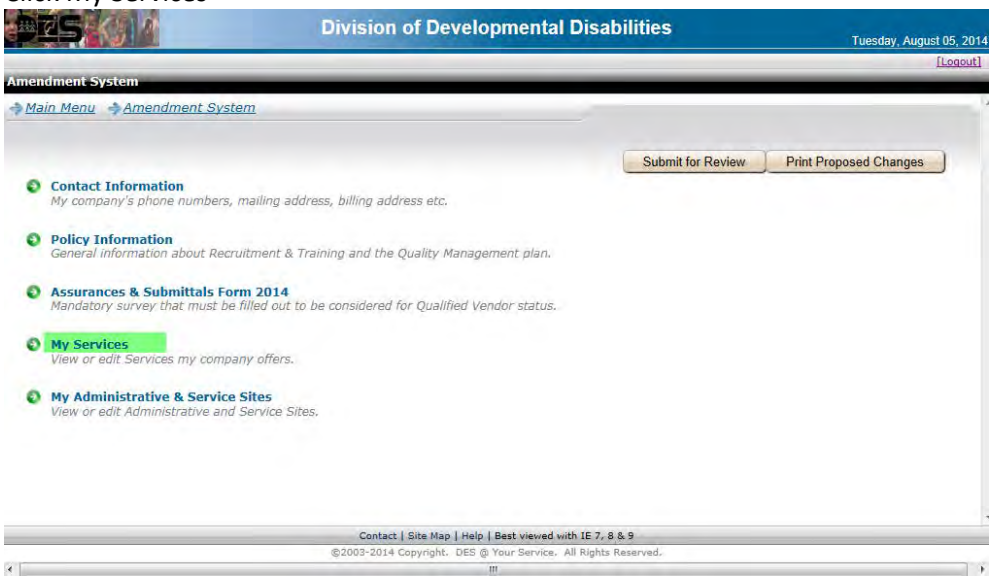


2 Updating the Agency with Choice Selection

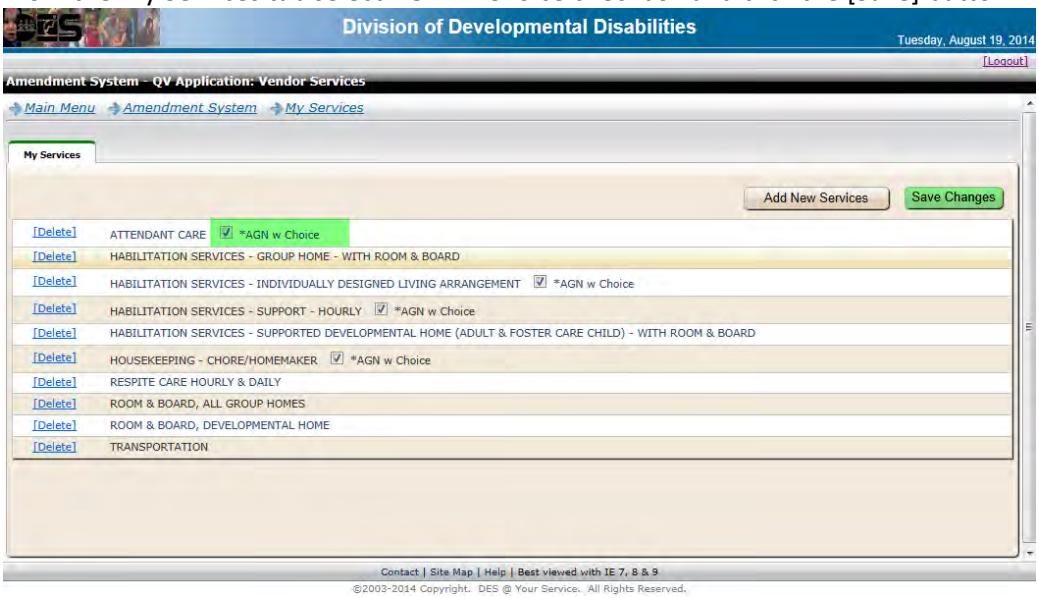
1. Click Amend my Contract



2. Click My Services



3. From the My Services tab select AGW w Choice checkbox and click the [Save] button.



NOTE: The **Agency with Choice** option is **only available** for the following services: **Attendant Care**, **Habilitation - Hourly Support, Habilitation - Individually Designed Living Arrangement** and **Homemaker (formally Housekeeping)**.

No amendment submission is required to select the Agency with Choice option it will show immediately.

Vendors can enroll at any time even if they have an amendment submitted for review.

The Agency with Choice option can only be deselected once all open 'Agency with Choice' member authorizations are not open and/or active.

DDD Agency With Choice User Guide – FOCUS Vendor

Version 1.0

July 28, 2014

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Division of Developmental Disabilities

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1. Introduction

Agency with Choice is a member-directed option that is available to home-based ALTCS members. Under the Agency with Choice option, the provider agency and the member enter into a co-employment relationship and share employer-based responsibilities for the paid caregiver. The provider agency maintains the authority to hire and fire the caregiver and provide or arrange for the required minimum standardized training for the caregiver.

Member directed models or options allow members to have more control over how certain services are provided, including services like attendant care, personal care and housekeeping – HSK, HAI, ATC and HAH. The models are not a service, but rather define the way in which services are delivered. Member-directed options are available to most Arizona Long Term Care System (ALTCS) members who live in their own home. The options are not available to members who live in an alternative residential setting or nursing facility. ALTCS members or their representatives are encouraged to contact their case manager to learn more about and consider member-directed options.

2. Changes in FOCUS Vendor Application

The following changes will be seen in FOCUS Vendor application by Vendors that opted for Agency With Choice.

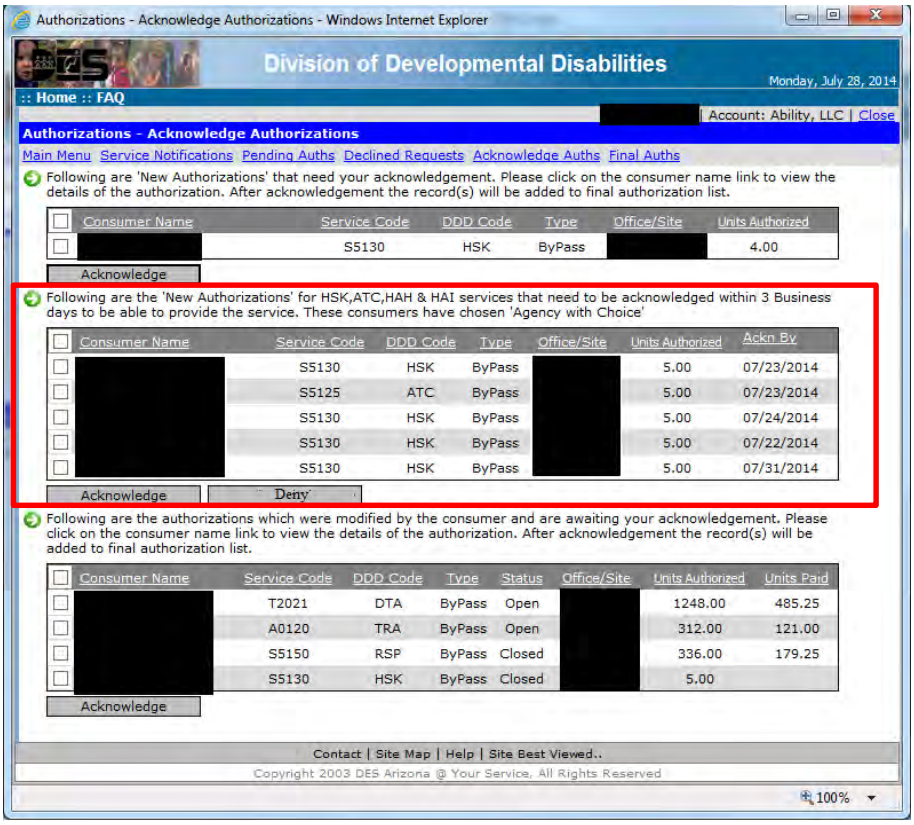
2.1 Acknowledge within 3 business days

User needs to log in to the FOCUS Vendor application > Service Authorizations > Acknowledge Authorizations

User will see a new grid displaying the list of members with 'AWC' authorizations awaiting for acknowledgement within 3 business days. User as a choice to select the members and 'acknowledge/deny' within 3 busniess days. Unacknowledged AWC authorizations in this grid past the 3 business day rule will be automatically terminated.

Example:

Count for Authorizations awaiting acknowledgement/deny within 3 business days is displayed on the Service authorizations main screen require AWC Count



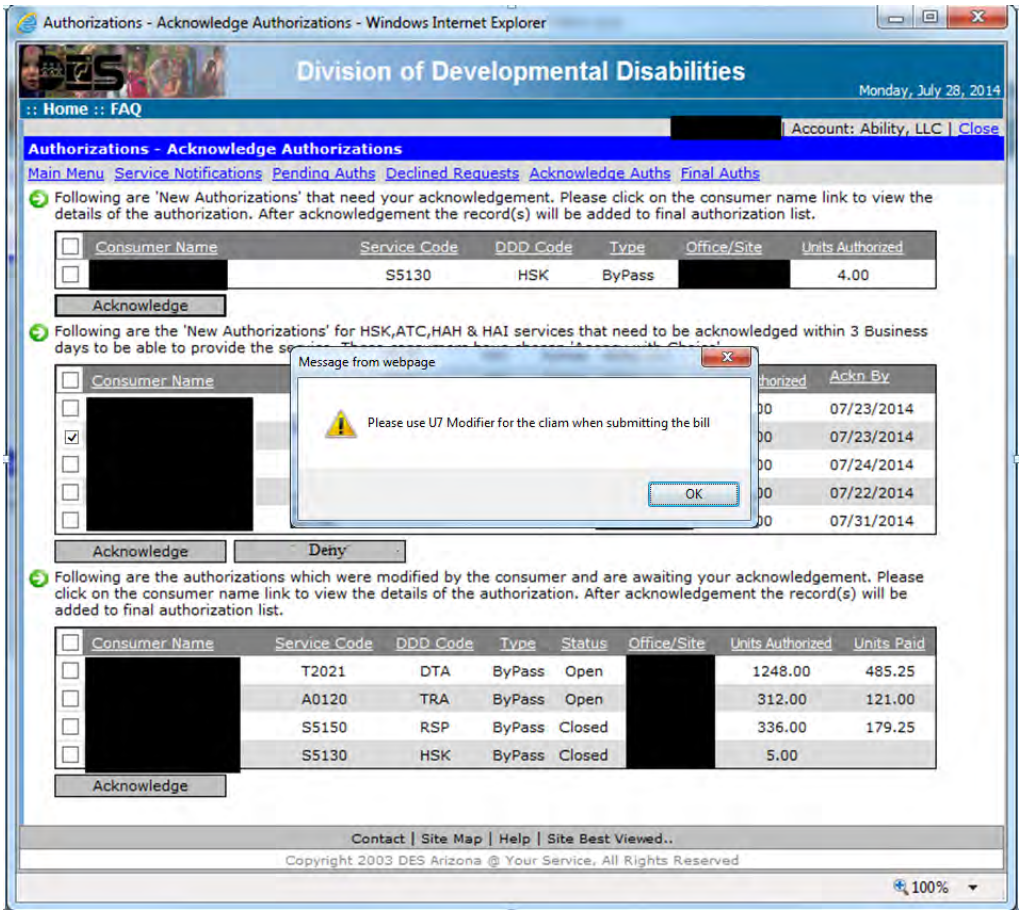
User will be able select members and Acknowledge/Deny the authorization.

2.2 Use U-7 modifier

User needs to log in to the FOCUS Vendor application > Service Authorizations > Acknowledge Authorizations > Select a member with authorization created with AWC

Upon Acknowledgement, user will be prompted to use U-7 modifer for submitting claims for services provided under Agency with choice option.

Example:



Introduction

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System Administration (AHCCCSA) to oversee and report on the utilization of medical services of AHCCCS's prepaid capitated Contractors. DDD is an AHCCCS prepaid capitated Contractor. DDD reports service utilization on an encounter. An encounter is a record of a service rendered by a provider who is registered with AHCCCS to a recipient who is enrolled with DDD. DDD is required to submit encounters to AHCCCS for all services.

CMS requires AHCCCS to submit progress reports on the encounter data collection process. AHCCCS must take appropriate action to correct deficiencies identified in the collection of encounter data and enforce financial penalties on Contractors that are not in compliance with data collection requirements.

AHCCCS's encounter collection actions are based on the results of encounter data validation studies. Collecting accurate, timely and complete encounters is a high priority for AHCCCS. Encounter data is used to support programmatic budget assumptions and in actuarial analyses to set capitation

rate ranges. In addition, this data is used for AHCCCS Contractor Performance Measures and Performance Improvement Projects.

This document provides DDD and its Providers with the methodology and statistical formulae used in Encounter Data Validation. These processes may change year to year and this document will be updated accordingly.

Annual Encounter Data Validation Study

On an annual basis, the AHCCCS Division of Health Care Management (DHCM) conducts an Encounter Data Validation Study. The purpose of this study is to compare recorded utilization information from claim or other source with DDD's submitted encounter data. Any and all covered services may be validated as part of this study.

Errors resulting from this study may fall into several categories defined as:

- Omission Error - an encounter for a medically related service for which a Contractor incurred a financial liability not submitted to AHCCCS. Or, an encounter inappropriately voided from AHCCCS historical files and not resubmitted, but still appearing as a paid claim for the Contractor is an omission.
- Accuracy Error - an inconsistency between the claim documentation and an encounter submitted in respect to member ID, Provider ID/NPI, procedure, modifiers, diagnosis, date of service, billed charged, paid amount, units, coordination of benefits.

- Timeliness Error - an encounter received at AHCCCS beyond the allowable time period as defined in the contract.

Encounter Data Validation Study Steps

Approximately 9 months after the end of a contract year, encounter extract files are generated from AHCCCS Data Warehouse based on adjudicated encounter data for each Contractor.

AHCCCS will request an extract from the Contractor's claims system. Upon receipt of the requested claims file extract, AHCCCS will sort and prepare the file for matching through the data validation process. Random sample files will be created for each of the study measures. The review scope will include two sections: Acute study "A" for all professional services and the Acute study "B" for all facility services. The studies will measure:

- Claims included in the Contractor's claim submission and encountered in AHCCCS' Prepaid Medical Management Information System (PMMIS) (Match) – to be reviewed for accuracy and timeliness.

- Claims included in the Contractor's claim submission but not encountered in PMMIS (NotEnc InClm) – to be reviewed for omission.
- Encounters reported in PMMIS but not included in the Contractor's claim submission (InEnc NotClm) – to be reviewed for omission from claim submission file.

Once the samples have been determined, the Contractor will be notified. For each record identified on the samples, the Contractor will be required to submit a copy the claim (or EDI) submitted by the provider, along with any other pertinent information such as, primary insurance EOB, AHCCCS CRN, proof of timely encounter submission, explanation for omission from claim file extract, etc. The Contractor will return all documentation to the SFTP server.

Once the Contractor's response is received, AHCCCS will review the documentation against the encounter data in PMMIS. Preliminary findings will be reported back to the Contractor. The Contractor will have 30 days to challenge the preliminary findings. Once all challenges have been considered, a final report will be generated and sent to the Contractor. Sanctions are applied based on the final report.

Random Sample Calculation

The health plans should send DAR the Plan Data, datasets required in a fixed width text format according to the attachments to the preliminary letters, which contain Np records. DAR analysts pull the Agency Data from AHCCCS Data Warehouse following exactly the same formats and time period as the Plan Data. Then following the below process the random samples are selected.

1. Assuming the health plans send the complete datasets to AHCCCS using SPSS or other software to do the data manipulation, match the plan data to the agency data and find the number of omission claims. This data matching includes three steps:

    a. Step 1. Match the Plan Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, Procedure Code (Study A) or First Revenue Code (Study B). Most of plan data records can be found in agency data and some of the plan data are omissions. Part of the result of this step is also for internal use.

b. Step 2. Match the omission data from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions. Part of the result of this step is also for internal use.

c. Step 3. Match the omission data from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions, which result in the overall omission number N_o

2. The overall omission rate is calculated as $i_o = N_o / N_p$, where N_o is from Step 3 and N_p is from the plan data.

3. Using statistical method by SPSS or Excel to select a random omission sample datasetof 500 records from the overall omissions. If the omissions are less than 500, select them all.

4. DAR analysts manually check each of these 500 records in AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions are truly omissions and

come up with a number N_r,(i.e. how many records are not found in PMMIS by any chance.) A random sample rate i_r is calculated as $i_r = N_r /500$, where thenumber of 500 can be substituted by the actual number if $N_o<500$.

5. The final omission rate $\boldsymbol{i_f}$ is calculated as $\boldsymbol{i_f = i_r * i_o = (N_o / N_p) /(N_r /500)}$, where thenumber of 500 can be substituted by the actual number if $N_o<500$.

Example of Random Sample Calculation

In this example, assume that Nearly Perfect Health Plan sends a complete Study A dataset to AHCCCS in a fixed width text format which contain Np =3,283,651 records. DAR analysts pull the agency data from AHCCCS Data Warehouse following exactly the same formats and time period as the Nearly Perfect Data. Then following the below process the random samples are selected.

1. Using SPSS or other software to do the data manipulation, match the Nearly Perfect Data to the Agency Data and find the number of omission claims. This data matchingincludes three steps:

a. Step 1. Match the Nearly Perfect Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, and Procedure Code. Most of the3,283,651 records can be found in agency data and 705,382 records are omissions. This number is also for internal use.

b. Step 2. Match the 705,382 records from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, and Service Provider Number. Some of omission records can be found in the agency data and 683,176 are still omissions. This number isalso for internal use.

c. Step 3. Match the 683,176 records from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, and Service Provider Number. Some of omission records can be found in agency data and 652,928 records are still omissions, i.e. the overall omission number N_o=652,928.

2. The overall omission rate is calculated as i_o =19.9 %(

652,928/3,283,651).

3. Using the statistical methods by SPSS or Excel to select a random omission sampledataset of 500 records from the overall omissions since N_o>500.

4. DAR analysts manually check each of these 500 records in the AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions aretruly omissions and come up with 16 records that are not found in PMMIS by any chance. The random sample rate i_r is calculated as i_r = 3.2 %(16/500).

5. The final omission rate $\boldsymbol{i_f}$ is calculated as $\boldsymbol{i_f}$ **=** 0.6 %(19.9%*****3.2%).

Sanctions

Sanction Calculation

The sanction amount by Contractor is calculated by applying the sanction formula:

S = P x ((L - A) x NAdj), where:

S = sanction amount,

P = per-error sanction amount,

L = lower limit of the confidence interval,

A = allowable error rate of 5%, and

NAdj = total number of encounters by form type adjusted for omissions by Contractor.

NAdj = Ntot / (1-LOm), where:

NTot = total number of encounters submitted by form type by Contractor, and

LOm = the lower limit of the omission error by Contractor.

The per-error base sanction amounts are:

ERROR TYPE	**SANCTION AMOUNT**
Omission	$5.00
Accuracy	$5.00
Untimely	$2.00

Guidelines

Response Documentation Guidelines

In order to properly submit the claims file extract to AHCCCS, these guidelines must be followed:

Acceptable form submission files examples:

1. Number each file submission to match the Row on the excel spreadsheet.
2. One file numbered to match spreadsheet which holds all the documentation for that row.

   Example (Use for all audit file submissions)

   AHCCCS ID # (Folder name)

   a. Add all documentation needed to support claim/encounter into one folder with the row number

   b. Make sure if using your own ID for members to add AHCCCS ID to your documentation.

3. Do this for each row on spreadsheet

4. Do not put all documentation all in one word document, pdf document, or insert into spreadsheet.

5. Zip all the individual files into one zip file and upload to AHCCCS server under “Other” and the particular health plan.

Focused Audits Override / Void Logs

At its discretion AHCCCS may conduct focus audits.

The Contractor is required to maintain logs for all overridden or voided encounters. Those logs are submitted quarterly pursuant to the Encounter Manual. AHCCCS will conduct periodic focused audit of the logs. The purpose of the audit is to ensure the override/void was an appropriate action.

From the information provided on the logs, AHCCCS will select a file sample. The file sample will be forwarded to the Contractor with a request for the documentation used to override or void the encounter. The Contractor will follow the guidelines below to support each override or void. AHCCCS will review the documentation for appropriateness and return the findings to the Contractor.

Override Log Audit Guidelines

Provide all documentation that supports the reason for the override of the encounter – including any guidelines, Medical Director approval, policy, etc.

If replaced with another CRN, please include CRN information

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in "Other" folder.

Void Log Audit Guidelines

Provide all documentation that supports the reason the encounter was voided.

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in "Other" folder.

101 MARKETING

REVISION DATE: 3/13/2024, 4/29/2020

REVIEW DATE: 6/19/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: Section F3, Contractor Chart of Deliverables; ACOM Policy 101 Attachment A Marketing Attestation Statement; ACOM Policy 101 Attachment B, Marketing Activities Report; A.A.C. R9-22-501 et seq, A.A.C. R9-28-501 et seq, A.A.C. R9-31-501 et seq, 9 A.A.C. 34; 42 CFR 438.10(a), 42 CFR 438.104, 45 CFR 155.20

PURPOSE

This policy establishes guidelines and restrictions for Administrative Services Subcontractors (AdSS) and their Subcontractors to remain in compliance when developing or using Marketing Materials or participating in Marketing activities related to AHCCCS and the Division.

DEFINITIONS

1. "Arizona Health Care Cost Containment System" or "AHCCCS" means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver

Demonstration Program and described in A.R.S. Title 36, Chapter 29.

2. "Administrative Services Subcontractor" or "AdSS" means an agreement that delegates any of the requirements of the Contract with AHCCCS to a person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor,
3. "Dual Eligible" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: a Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).
4. "Dual Eligible Special Needs Plan" or "D-SNP" means a type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII)

program covered health benefits and full Medicaid (Title XIX) program covered health benefits.

5. "Dual Marketing" means Marketing efforts specifically targeting a Division Member who is eligible for Medicare and Medicaid.
6. "Financial Sponsor" means any monies or in-kind contributions provided to an organization other than attendance fees or table fees, to help offset the cost of an event.
7. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record.
8. "Marketing" means any communication from Contractors to a Member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Member to enroll with the Contractor, or to not enroll or disenroll with another Contractor's Medicaid product as specified in 42 CFR 438.104. Marketing does not include communication to any Member about a Qualified Health Plan, as specified in 45 CFR 155.20.

9. "Marketing-Health Message" means a slogan or statement on Marketing Materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.
10. "Marketing-Health Related" means an event that has a direct or indirect health care purpose, or it supports or contributes to any AHCCCS initiative or program goal. Giveaway items shall have a Health Message or a health care purpose to be considered health-related.
11. "Marketing Materials" means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended for Marketing purposes. This includes general audience materials such as general circulation brochures, Contractor's website and other materials that are designed, intended, or used to increase Contractor Membership or establishing a brand.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "Potential Member" means a Medicaid-eligible recipient who is not yet enrolled with a Contractor or a Member during Annual Enrollment Choice (AEC).
14. "Promotion" or "Promotional" means any activity in which Marketing Materials are given away or displayed with the intent to increase the Contractor's membership.
15. "Rural County" means a county that has been designated as non-urban by the United States Census.
16. "Social Networking Application" means web-based services or platforms, excluding the Contractor's State mandated website content, Member portal, and provider portal, for online collaboration that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and instant messaging services – collectively also referred to as social media.
17. "Subcontractor" means

a. A provider of health care who has contracted with an AdSS to furnish covered services to Members;

b. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities; or

c. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease, or leases of real property, to obtain space, supplies equipment or services provided under the AHCCCS agreement.

POLICY

A. MARKETING MATERIALS, GIVEAWAYS, EVENTS, SPONSORSHIPS, PRESS RELEASES AND ADSS AND DIVISION LOGO NAME USE

1. Materials and Giveaways

a. The AdSS shall only use Member Marketing Materials during Marketing activities that have been previously

approved as Member information under AdSS Operations Policy Manual, Policy 404 if they comply with the requirements of this policy.

b. The AdSS shall submit a description and image of Marketing Materials and Marketing items or giveaways for approval to the Division as required under this policy and as specified in the Division Contract.

c. The AdSS shall only distribute Marketing Materials and giveaways for up to two years from the date of approval.

d. The AdSS shall submit any changes or amendments to previously approved materials to the Division for approval prior to use.

e. The AdSS shall submit templates for flyers or posters that advertise regular meetings or events where only the dates and times of the events change.

f. The AdSS may distribute previously approved templates for a period of up to two years from the date of approval.

g. The AdSS shall only distribute health educational materials without prior Division approval if the materials:

   i. Include health-related and developed based on information from an approved recognized organization found in ACOM Policy 404, Attachment A.

   ii. Do not include AdSS specific information related to the Division Integrated Contract.

h. The AdSS shall ensure that:

   i. The value of any Marketing item or giveaway given to the general public by the AdSS does not exceed $15.00;

   ii. Giveaway items are health related, or if not health-related, include a Health Message on the item;

   iii. All Marketing Materials identify the AdSS as a Division provider and are consistent with the

requirements for information to Members described in the AHCCCS Contract and in Division policies;

iv. All Marketing Materials that have been produced by the AdSS and refer to contract services specify: "Contract services are funded in part under contract with the State of Arizona Department of Economic Security/Division of Developmental Disabilities;"

v. Marketing Materials distributed by the AdSS are distributed to its entire contracted GSA population;

i. The AdSS shall not:

i. Market directly to Members eligible for the Division; or

ii. Encourage or induce a Member to select a particular AdSS when completing the application; or

iii. Complete any portion of the application on behalf of the Potential Member, this prohibition covers all situations, whether sponsored by the AdSS, their parent company, or any other entity.

2. Events

   a. The AdSS shall only participate in Health-Related Marketing events that are listed as pre-approved events in Section (A)(2)(e) of this policy, if the event is either:

      i. Health related; or incorporates a

      ii. Health education component.

   b. The AdSS shall submit a request for prior approval to AHCCCS if the event is not listed as a pre-approved event as specified in the AdSS contract containing the event name, date, location and address.

   c. The AdSS participation in events shall include AdSS staff in attendance and available to respond to participants.

   d. The AdSS shall only attend events after receiving approval from the Division when the following criteria apply:

      i. The AdSS pays sponsorship fees;

      ii. The AdSS donates benefits or items;

      iii. The AdSS distributes materials not previously approved by the Division within the last two years;

iv. The AdSS is not certain if an event would qualify as pre-approved.

e. The AdSS may attend the following pre-approved, health related events:

i. Back to School Events;

ii. College or University Events;

iii. DES Health or Resource Events-if open to all AHCCCS plans;

iv. Women, Infants and Children (WIC) Health or Resource Events-if open to all AHCCCS plans;

v. Events where health education is a component;

vi. Jobs Fairs as specific in Contract and ACOM Policy 407;

vii. Community Center or Recreational Events;

viii. Community or/ Family Resource Events;

ix. Provider Events that the AdSS is contracted with;

x. Faith Based Events;

xi. Farmers Market Events;

xii. Health Educations Forum, community sponsored;

xiii. Safety Events;

xiv. Immunization Clinics;

xv. Senior Events;

xvi. Shopping Mall Events; and

xvii. Division's Event that is created and sponsored by the Division for its own Members only.

f. The AdSS shall not participate in Marketing activities at the following events:

i. Events that are not health related or do not have a health education component;

ii. DES offices, except those listed on the approval list;

iii. WIC Offices, except those listed on the approval list;

iv. Job Fairs, except those listed on the approval list;

v. County or State Fairs;

vi. Bi-national Health Events;

vii. Political Events;

viii. Pharmacy Events not open to all AdSSs;

ix. Swap Meets;

x. AdSS's Event that is created and sponsored by the AdSS or through its affiliates for Division Members not enrolled with the AdSS, or for the general public; or

xi. Any event determined by the Division to not be in the best interest of the State of Arizona.

3. Sponsorships

a. The AdSS shall only participate as a Financial Sponsor of Health-Related Marketing events that have been pre-approved and listed in Section A.2.e. of this policy.

b. The AdSS shall submit a request to the Division prior to participation as a Financial Sponsor of Health-Related Marketing events that contains information as described in Section A.2 of this policy, in addition to the following criteria:

i. The dollar amount of the participation broken down and listed individually by each line of business; and

ii. Either a copy or description of any materials, including websites, on which the AdSS's name or logo will appear at the sponsored event, prior to production.

4. Press Releases

The AdSS shall only issue press releases or announcements about program innovations and events that promote the goals of the Division.

i. Press releases that do not include AdSS-specific information related to the Division Integrated Contract do not require prior Division approval.

ii. All other press releases shall be submitted to the Division for prior approval.

5. AdSS Logos and Name Inclusion

a. The AdSS shall prevent misuse of their name and logo.

b. The AdSS may include the AdSS's logo without requesting prior approval on event flyers or websites that are

produced by hosting organizations, if the Division has approved the event.

c. The AdSS shall not allow use of the AdSS's name or logo for television advertising of the event.

iii. If the AdSS is a Financial Sponsor for the event, the event flyers or websites will require prior approval by the Division.

B. RESTRICTIONS

The AdSS shall prohibit the following Marketing activities:

a. Solicitation of any individual, whether directly or indirectly;

b. References to a competing AdSS;

c. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;

i. For the purposes of this policy, Qualified Health Plans are not considered private insurance, and

ii. The AdSS may discuss its affiliated Qualified Health Plan in Promotional materials, however, the AdSS is

a separate legal entity from all other affiliated health plans and is therefore subject to restrictions on the use of Protected Health Information (PHI).

d. Television advertising;

e. Direct mail advertising;

f. Social Networking Applications as described in AdSS Policy Manual, Policy 425;

g. Marketing of non-mandated services;

h. Utilization of the word "free" in reference to covered services;

i. Listing of providers in Marketing Materials who do not have signed contracts with the AdSS;

j. Use of the Arizona Department of Economic Security, Division of Developmental Disabilities logo or AHCCCS logo;

k. Inaccurate, misleading, confusing or negative information about the Division or the AdSS; and any information that may defraud Members or the public;

l. Discriminatory Marketing practices as specified in A.A.C. R9-22-501 et seq, A.A.C. R9-28-501 et seq, A.A.C. R9-31-501 et seq;

m. AdSSs providing services in a GSA where its enrollment is capped to prohibit Members from selecting the AdSS may not engage in Marketing activities in that GSA, but may engage in outreach and retention activities with its current Members;

n. Marketing Materials containing any assertion or statement, whether written or oral, that the Member is required to ~~must~~ enroll with the AdSS to obtain benefits or to not lose benefits;

o. Marketing Materials containing any assertion or statement, whether written or oral, that the AdSS is endorsed by CMS, the Federal or state government, or a similar entity; and

p. Other restrictions as determined by the Division.

C. DUAL ELIGIBLE MARKETING

1. The AdSS shall submit to the Division all Dual Marketing Materials that:
    a. Have not been approved by CMS; or
    b. Includes reference to Division benefits; or
    c. Includes Division service information.
2. The AdSS shall adhere to the following restrictions regarding use of billboards that use the terms 'Medicaid' or 'AHCCCS':
    a. Limited to two in each urban county; Maricopa and Pima; and
    b. Limited to one in each Rural County.

D. AdSS RESPONSIBILITIES

1. The AdSS shall submit to the Division ACOM 101 Attachment B, Marketing Activities Report, containing Marketing costs, including:
    a. The previous six months of Marketing activities in which the AdSS was a participant as-separate line items in the quarterly financial statements; and

b. Any Marketing costs included in an allocation from a parent or other related corporation.

2. The AdSS shall review and revise all Marketing Materials on a regular basis in order to reflect current practices.

3. The AdSS shall submit any changes or amendments to previously approved Marketing Materials in advance to the Division for approval as indicated in this policy.

4. The AdSS CEO or their designee shall sign and submit to the Division, ACOM 101, Attachment A, Marketing Attestation Statement, as adopted by the Division and as specified in Section F3, Contractor Chart of Deliverables, addressing the compliance of its plan with the requirements of this policy.

E. SUBMISSION REQUIREMENTS

1. The AdSS shall submit all Marketing Materials including, giveaways, event requests, sponsorships, advertisements including the publications in which they will be placed, press releases, and Dual Eligible Marketing Materials as individual requests to the Division for approval at least 21 days prior to

dissemination as specified in the AdSS Contract with the Division.

2. The AdSS shall not submit Bulk submissions, containing more than one event, sponsorship, or press release, with the exception of giveaway items.
3. The AdSS shall submit giveaway items for approval separately from any event or sponsorship submission and may consist of more than one giveaway.
4. The AdSS shall submit advertisements, the publications in which the ad will be placed, to the Division for approval.
5. The AdSS shall ensure Marketing Material submissions are complete and include all corresponding documents.
6. The AdSS shall ensure the following criteria are completed when requesting an expedited review of Marketing Materials, when a 21-day notice is not possible:
    a. Follow the submission requirements as noted in this section;

b. Submit notification of the expedited request to the Division's Compliance Unit, ensuring expedited notification is clearly marked; and

c. Indicate the reason for the shortened time frame.

7. The AdSS shall resubmit any Marketing Materials to the Division for review and approval if any substantive changes or modifications of previously approved materials have been made, with the inclusion of:

   a. Date the material was previously approved;

   b. Reason for update; and

   c. All clearly identified content revisions.

8. The AdSS shall request a reconsideration of any Division decision by submitting a written request for reconsideration to the Division Compliance Unit and following the submission requirements for Marketing Materials as specified in the AdSS Contract with the Division.

9. The AdSS shall provide information to the Division in support of the AdSS' request for reconsideration.

103 FRAUD, WASTE, AND ABUSE

REVISION DATE: 4/10/2024

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901, A.R.S. § 36-2918, A.R.S. § 36-2957, A.R.S. §36-2903.01(K); A.A.C. R9-22-702; 42 CFR 455.101, 42 CFR 438.608, 42 CFR Part 438, Subpart H, 42 CFR 455, 42 CFR 455, Subpart A, 42 CFR 455, Subpart B, 42 CFR 455.2, 42 CFR 455.23, 42 CFR 455.101, 42 CFR 455.436; ACOM Policy 103; Division Operations Policy 103; State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act

PURPOSE

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). The purpose of this policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged Fraud, Waste, or Abuse, involving services funded by the Division. This policy also addresses additional responsibilities regarding regulatory compliance with broader program integrity and programmatic requirements.

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
    a. Claims processing, including pharmacy claims
    b. Pharmacy Benefit Manager (PBM)
    c. Dental Benefit Manager
    d. Credentialing, including those for only primary source verification through Credential Verification Organization (CVO)
    e. Medicaid Accountable Care Organization (ACO)

f. Service Level Agreements with any division or subsidiary of a corporate parent owner; providers are not AdSS.

g. CHP and the Division Subcontracted Health Plan

i. A person, individual or entity, who holds an Administrative Services Subcontract is an administrative services subcontractor.

ii. Providers are not administrative services subcontractors.

3. "Agent" -means any person who has been delegated the authority to obligate or act on behalf of a Provider as specified in 42 CFR 455.101.

4. "Contract" means the AdSS contract with the Division.

5. "Corporate Compliance Officer" means an individual located in Arizona and who implements and oversees the AdSS Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector

General. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position. The Corporate Compliance Officer shall be an onsite management official who reports directly to the ~~Contractor's~~ AdSS Chief Executive Officer (CEO) and Board of Directors, if applicable. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract as specified in 42 CFR 438.608.

6. "Credible Allegation of Fraud" means the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. as specified in 42 CFR 455.2.
7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2..

8. "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency as outlined in 42 CFR 455.101.
9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
10. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with the Division to provide services to Division Members.
11. "Waste" - means overutilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. The AdSS shall:

1. Have in place internal controls, policies, and procedures to:

a. Prevent, detect, and report credible Fraud, Waste, and Abuse activities to the Division.

b. Implement a suspension, termination, or exclusion of a provider from the ADSS network of providers.

2. Have a Corporate Compliance Program that complies with the AdSS's contract with the Division and all state and federal laws, including 42 CFR Part 438, Subpar H and is developed under the AdSS corporate compliance plan including:

a. Program integrity goals and objectives;

b. Descriptions of internal and external controls employed by the AdSS to ensure compliance with State and Federal law; and

c. The AdSS's corporate compliance activities, as outlined in ACOM 103.

3. Submit the AdSS written Corporate Compliance Plan to the Division annually, as specified in the Contract.

4. Submit to the Division an external audit plan/schedule and audit report of all individual provider audits using ACOM 103

Attachment C as specified in Section (F)(3) of the AdSS contract with the Division, Contractor Chart of Deliverables.

a. In each audit report, the AdSS shall include:
    i. An objective, scope, estimated dollars at risk, current audit results, key audit findings, recommendations, corrective actions required, and conclusion;
    ii. Copies of the report for each audit scheduled and completed; and
    iii. If an audit was not completed timely, include a reason why and a date when the audit will be completed.

b. AdSS shall submit a minimum of 20 audits semiannually.

c. The AdSS shall submit follow-up audits on a separate ACOM 103 Attachment C and not count towards the required minimum audit numbers as stated above in this subsection.

5. Submit complete, accurate, and current disclosure information, as described in 42 CFR Part 455, Subpart B and as specified in Contract, upon execution of a Contract with the State and upon renewal of extension of the Contract utilizing Attachment A and Attachment A-1.
    a. The AdSS shall ensure review of its response by its legal counsel prior to submitting disclosure information.
    b. As specified in Contract, the AdSS shall submit all information electronically, without any exceptions.
    c. AHCCCS/Office of Administrative Legal Services (OALS) and AHCCCS-OIG reviews the AdSS submitted disclosure information for completeness and AHCCCS-OIG screens and confirms that persons listed in the submitted information are not excluded from participation in the Medicaid program.
6. Complete all information as specified in ACOM 103 Attachment A and Attachment A-1 to enable AHCCCS-OIG to confirm that

persons with an ownership or control interest in the AdSS are not excluded from participation in the Medicaid program.

a. The AdSS shall obtain and disclose the information regarding the ownership and control interest of its subcontractors.

b. The AdSS shall retain the results of the disclosure of ownership and control and the disclosure of information on persons convicted of crimes and reported to the Division.

c. The AdSS shall complete and submit an attestation as specified in ACOM 103 Attachment A along with the disclosure information described in this subsection and that the information provided is accurate, complete, and truthful.

d. Consistent with 42 CFR 457.990 and 42 CFR 438.606, the AdSS Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to

sign for the Chief Executive Officer or Chief Financial Officer shall sign the attestation.

e. Failure to provide all complete and accurate disclosures and an attestation signed by an individual with appropriate authority may result in the withholding of payments under the Contract or the recovery, recoupment, or offset of any monies remitted without limitation.

7. Disclose, and require its subcontractors to disclose, to the Division the identity of any employee or person with ownership or control interest who is excluded from participation in any federal healthcare programs.
8. Comply with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 457.1285, and 42 CFR 438.608(a)(6)].
9. As a condition for receiving payments, establish written policies, and ensure adequate training and ongoing education for, all of its employees, including management, Members, and of any subcontractors or Agents of the AdSS regarding the following:

a. Detailed information about the Federal False Claims Act;

b. The administrative remedies for false claims and statements;

c. Any state laws relating to civil or criminal penalties for false claims and statements; and

d. The whistleblower protections under such laws.

10. Ensure adequate training addressing Fraud, Waste, and Abuse prevention, recognition and reporting, and encourage employees, Members, and any subcontractors to report Fraud, Waste, and Abuse without fear of retaliation.
11. Ensure an internal reporting process relating to the reporting of Fraud, Waste, or Abuse that is well-defined is made known to all employees, Members, and any subcontractors.
12. Conduct research and proactively identify changes for program integrity that are relevant to the corporate compliance program, and periodically review and revise the Fraud, Waste, and Abuse policies or guidance from the Division or AHCCCS to reflect such changes due to rules, regulations, or new initiatives.

13. Regularly attend and participate in Division work group meetings.
14. Respond promptly and not later than 20 days to requests for information from the Division.
15. Cooperate with the Division regarding any allegation of Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.
16. Have a method of verifying with Division members that they received the services billed by Providers to identify potential service or claim fraud.
17. Perform periodic audits through Member contact and report the results of these audits to the Division as specified in ACOM Policy 424.
18. Maintain Compliance with all State and Federal laws and regulations related to Fraud, Waste, and Abuse, even if not directly specified in this policy.

B. REPORTING RESPONSIBILITIES

1. Fraud, Waste, and Abuse

a. If an AdSS discovers, or is made aware, that an incident of alleged Fraud, Waste, or Abuse has occurred or is occurring, the AdSS shall immediately report the incident to AHCCCS-OIG as specified in Contract and by completing and submitting the "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program" form available on the AHCCCS-OIG webpage, and attach all pertinent documentation that could assist AHCCCS in its investigation shall be attached to the form,;

b. If the AdSS identifies an incident that warrants self-disclosure, the AdSS shall report the incident within ten calendar days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage and attach all pertinent documentation that could assist AHCCCS in its investigation.

c. When the AdSS has referred a case of alleged Fraud, Waste, or Abuse to AHCCCS-OIG, the AdSS shall take no

action to recoup, offset, or act in any manner inconsistent with AHCCCS-OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, or impose a civil monetary penalty;

d. The AdSS shall conduct preliminary review work regarding a referral at the request of AHCCCS-OIG in order to expand the allegation and obtain documentation to support the investigation being conducted by AHCCCS-OIG;

e. The AdSS shall provide documentation requested by AHCCCS-OIG within 30 calendar days of the request.

f. The AdSS may receive notification from AHCCCS-OIG when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation;

g. The AdSS shall ensure proper disposition of any matters returned by AHCCCS-OIG as non-medicaid Fraud, Waste, or Abuse in accordance with any applicable laws and contracts;

h. The AdSS shall adhere to the requirement that AHCCCS-OIG has the sole authority to handle and dispose of any matter involving Fraud, Waste, or Abuse and assigns to AHCCCS the right to recoup any amounts overpaid to a Provider as a result of Fraud, Waste, or Abuse.

i. The AdSS shall forward anything of value that could be construed to represent the repayment of any amount expended due to Fraud, Waste or Abuse that is recovered to AHCCCS-OIG within 30 days of its receipt.

j. As specified in the AHCCCS Minimum Subcontractor Provisions (MSPs), the requirements outlined in this section shall apply to any actions undertaken by the AdSS on behalf of a subcontractor.

k. The AdSS shall relinquish each, every, any and all claims to any monies, received by AHCCCS as a result of any program integrity efforts including:

    i. Recovery of an overpayment;

ii. Civil monetary penalties or assessments;

iii. Civil settlements or judgments;

iv. Criminal restitution;

v. Collection by AHCCCS or indirectly on AHCCCS' behalf by the Office of the Attorney General; or

vi. Other, as applicable.

l. The AdSS shall report to AHCCCS, as specified in Contract and the Division Medical Policy 950, any credentialing denials including:

i. That are the result of licensure issues;

ii. Quality of care concerns;

iii. Excluded, terminated, or otherwise sanctioned Providers; or

iv. Alleged Fraud, Waste, or Abuse.

C. THE ADSS' CORPORATE COMPLIANCE RESPONSIBILITIES RELATED TO FRAUD, WASTE, AND ABUSE

1. The AdSS shall:

a. Process all referrals of allegations of suspected Member and provider Fraud, Waste, or Abuse.

b. Oversee, monitor, and review all documents and functions as they relate to Fraud, Waste, and Abuse prevention, detection, and reporting.

c. Maintain and monitor a tracking system of Fraud, Waste, and Abuse investigations.

d. Ensure all employees, Providers, Agents, and Members receive adequate training and information regarding Fraud, Waste and Abuse prevention, identification and reporting.

e. Assure employees, subcontractors, Providers, Agents, and Members that they can report Fraud, Waste, and Abuse without fear of retaliation.

f. Develop and maintain open channels of communication with the Division, AHCCCS-OIG, subcontractors, Providers, Agents, and Members to combat Fraud, Waste, and Abuse at all levels in the System.

g. Make referrals to AHCCCS-OIG to investigate cases of potential Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.

h. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of providers to ensure their compliance.

i. Ensure the AdSS is in compliance with its federal obligations regarding disclosure of ownership and control, managing employees database exclusion, and checks, and criminal convictions checks, and all other federal requirements related to provider screening and enrollment.

SUPPLEMENTAL INFORMATION

1. AHCCCS/Office of Inspector General (AHCCCS/OIG) is responsible for reviewing suspected incidents of fraud, waste, and/or abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with the authority or

obligations vested in AHCCCS/OIG under State or Federal law, rule, regulations, or policies.

2. AUTHORITY

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations, relating to fraud, waste, and abuse, involving the programs administered by AHCCCS. Pursuant to 42 CFR 455.12-23 and an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

a. Pursuant to A.R.S. § 36-2918, AHCCCS-OIG has the authority to issue subpoenas and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony, as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the AHCCCS-OIG.

b. Pursuant to A.R.S. §§ 36-2918, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

c. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, AHCCCS-OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

d. Pursuant to federal law, AHCCCS-OIG shall suspend payments to providers where it determines that a credible allegation of fraud exists as specified in 42 CFR 455.23.

e. Pursuant to state and federal law, AHCCCS is required in certain circumstances, and in other circumstances it may, act to

suspend, terminate, or exclude any person (individual or entity) from participation in the AHCCCS Program.

3. The Division has adopted Attachment B of the AHCCCS Operations Manual, Policy 103. The AdSS can use the sample provided under Attachment B for guidance on how to present such compliance activities. The AdSS's written Corporate Compliance Plan must be submitted to the Division annually as specified in Section F3, Contractor Chart of Deliverables.

104 CONTINUITY OF OPERATIONS AND RECOVERY PLAN

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.207 and 42 CFR 438.208; Business Continuity and Recovery Plan Checklist (ACOM 104-Attachment A); Contract Section F, Deliverables

DELIVERABLES: Continuity of Operations and Recovery Plan Summary

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division requires in the contract that each of its AdSS have a Continuity of Operations and Recovery Plan to ensure restoration of business operations following unexpected events, or the threat of such events, which impact their ability to adequately serve members. The purpose of this policy is to outline the required components of the Continuity and Recovery Plan. Refer to the Resources section of this policy for more information in developing an emergency management plan.

Definitions

A. Administrative Services Subcontracts - An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification
3. Management Service Agreements
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

B. Continuity of Operations Programs (COOP) - An effort within the individual executive departments and agencies to ensure that essential functions continue to be performed during a wide range of emergencies.

The Division is mandated to provide health care benefits to its AHCCCS-eligible members. In order to provide benefits, the AdSS must be able to recover from any disruption in services as quickly as possible. This recovery can be accomplished by the development of a Business Continuity and Recovery Plan that contains strategies for recovery. The Continuity and Recovery Plan is part of the Federal Government's Continuity of Operations Programs (COOP) requirements.

AdSS Responsibilities

The AdSS must develop, maintain, and update annually a Continuity and Recovery Plan that assures the Division that the provision of covered services will occur as stated in the contract (42 CFR 438.207 and 42 CFR 438.208). As specified in contract Section F, Deliverables, a comprehensive summary of the AdSS's Continuity and Recovery Plan must be evaluated, updated, and submitted with a Continuity and Recovery Plan Checklist (AHCCCS Contractor Operations Manual Policy 104-Attachment A). The summary must be no longer than five pages and must address all Continuity and Recovery Plan requirements outlined below.

Continuity and Recovery Plan Requirements

A. The Continuity and Recovery Plan (Plan) must be reviewed and tested at least annually to manage unexpected events that may negatively and significantly impact the ability to deliver services to members and must be updated as needed by the AdSS.

B. The AdSS must ensure that all staff are trained and familiar with the Plan, and understand their respective roles.

C. The Plan must be specific to the AdSS's operations in Arizona and reference local resources. Generic plans that do not reference operations in Arizona and the AdSS's relationship to the Division are not acceptable.

D. The Plan must contain a listing of key customer priorities and key factors that could cause disruption and timelines for when the AdSS will be able to resume critical customer services when a disruption occurs.

E. These priorities include but are not limited to:

1. Providers receipt of prior authorization approvals and denials
2. Members receiving transportation
3. Timely claims payments.

F. The AdSS must also include any additional priorities as identified by the AdSS to be critical key priorities or factors.

G. The Plan must contain specific timelines for resumption of services as well as the percentage of recovery at certain hours, and the key actions required meeting those timelines.

Example: Telephone service restored to prior authorization unit within four hours, to Member Services within 24 hours, to all phones in 24 hours.

H. The Plan must contain, at a minimum, planning and training for:

1. Electronic/telephonic failure
2. Complete loss of use of the main site and any satellite offices in and out of State
3. Loss of primary computer system/records
4. Extreme weather conditions
5. How the AdSS will communicate with the Division during a business disruption (the name and phone number of a specific contact in the Division of Health Care Management is preferred)

   The Plan must direct the AdSS staff to contact the Division at 602-542-0419 in the event of a disruption outside of normal business hours.

6. Periodic testing, at least annually. Results of the test must be documented.

I. The AdSS must designate a staff person as Continuity Planning Coordinator and furnish the Division with contact information as part of the Plan.

J. The AdSS must require its subcontractors to develop and maintain a Continuity and Recovery Plan.

Resources

The Federal Emergency Management Agency (FEMA) website contains more information on continuity planning, including checklists for reviewing a Plan. The Division encourages the AdSS to use relevant parts of these checklists in the evaluation and testing of its own

Continuity Plan. The AdSS can also reference the Ready.gov website for supplementary information.

106 CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE-AHCCCS MEMBERS

EFFECTIVE DATE: October 1, 2019
REFERENCES: Social Security Act §1876

This Policy applies to the Division's Administrative Services Subcontractors (AdSS) pursuing and becoming Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan) serving dual eligible Medicaid and Medicare members. This Policy outlines the steps necessary to gain Medicare Advantage state certification by AHCCCS and the ongoing requirements to stay certified.

State certification is required as part of the CMS Medicare Advantage application. Under Arizona state law, certification of an AdSS serving persons who are eligible for Medicaid, including persons eligible for both Medicare and Medicaid (dual eligible members), can be completed by AHCCCS or through state licensure by the Arizona Department of Insurance (DOI).

AdSS serving dual eligible members can choose to be licensed by DOI, rather than certified by AHCCCS, if desired. However, if an AdSS does serve more than dually eligible Medicare and Medicaid members under its Medicare Plan, the AdSS must obtain certification by DOI and not AHCCCS. For current AdSS who have a MA Plan that serves members enrolled in the Arizona Long Term Care System Developmentally Disabled program, certification can be extended to include this population.

AHCCCS will only provide certification to AdSS if they are currently a Medicaid Contractor. . However, due to the timing of the MA Plan application process, AHCCCS may provide a conditional certification that would allow an AdSS to start the process of becoming an MA Plan during the Division bid process for a new contracting cycle. The certification would be conditional upon being awarded a contract for the new contracting period. Likewise, conditional approval will be made final if the Offeror is awarded a contract.

Definitions

A. Dual Eligible Member (for Purposes of this Policy) - A member enrolled with a Division's AdSS for Medicaid services who is also a Medicare beneficiary. These persons are considered full *dual* eligible members. A full dual eligible member does not include persons who are members of the Medicare Cost Sharing populations: Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).

B. Equity per Member - Net assets that are not designated or restricted for specific purposes divided by the number of Medicare Advantage Dual Eligible Members. Refer to the AdSS Operations Manual Policy 305 for further clarification.

C. Medicare Advantage Plan - An organization that provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.

D. Medicare Advantage- Prescription Drug/Special Needs Plan (MA-PD/SNP) - An organization that provides the full Medicare benefit, including prescription drugs, to a very specific group of Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act. Specific groups served may include members eligible for Medicare and Medicaid (dual eligibles) and/or members residing in nursing facilities.

E. Performance Bond - In general, a performance bond is an instrument that provides a financial guarantee in an amount of one month's capitation or an established amount per enrolled member.

AdSS Responsibilities

AdSS pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Request form to the AHCCCS Division of Health Care Management (DHCM), Medicare Administrator, at least 30 days prior to the date the certification must be sent to the Center for Medicare and Medicaid Services (CMS). The State Certification Request form can be obtained from the Medicare Advantage application on the CMS website at www.cms.gov.

In addition to the State Certification Request, AdSS must submit the following in narrative form:

A. Timing of start-up

B. Description of service area

C. Projected enrollment at start up and at the end of year one.

D. Projected amount and description of how equity per member requirements will be met initially and ongoing

E. Projected amount, and description of how performance bond requirements will be met initially and ongoing (refer to AdSS Operations Manual Policy 305 for performance bond requirements)

F. Statement of understanding regarding ongoing monitoring and reporting.

AHCCCS Process

A. Within two weeks of receipt of the State Certification Request, DHCM will notify the plan of the specific financial viability requirements and/or determine if additional information is necessary to approve the request.

B. Prior to the approval, DHCM will verify that the plan will be able to comply with the requirements by obtaining a specific plan of action addressing how the standards will be met.

C. Upon review and acceptance of the plan of action noted in B above, DHCM will forward a recommendation and the Certification Request to the AHCCCS Office of the Director for final signature and then back to the Contractor to be sent to CMS to continue the application process.

Financial Viability Standards and Reporting

To receive certification, the AdSS must be in compliance with current financial viability, claims, and administrative standards per the Division contract.

A. Performance Bond - The Division requires that the AdSS obtain and maintain a performance bond specifically for the purpose of the MA Plan in accordance with AdSS Operations Manual Policy 305.

B. Equity per Member - The Division requires that the AdSS maintain equity per MA Dual Eligible Member in accordance with AdSS Operations Manual Policy 305.

C. Ongoing Monitoring - The AdSS must self-monitor their compliance with the equity per member and performance bond requirements and to report to the Division when approaching non-compliance along with a corrective action plan. The Division reserves the right to investigate issues brought to the agency's attention related to the MA Plan.

D. Financial Reporting - The AdSS will be required to submit quarterly financial statements and an annual audit report and supplemental financial schedules reporting on the MA Plan line of business separately.

The AdSS must report financial data to the Division using the appropriate Division Financial Reporting Guide for the line of business to which the MA Plan is related.

108 AHCCCS SECURITY RULE COMPLIANCE

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.100(d) and 42 CFR 438.208(b)(4); 45 CFR Parts 160, 162, and 164; Section F3, Contractor Chart of Deliverables

DELIVERABLES: AHCCCS Security Rule Compliance Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Definitions

A. Breach - An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised. As stated in Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act issued in August 2009.

B. Health Insurance, Portability and Accountability Act (HIPAA) - The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

C. HIPAA Privacy Rule - The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

D. HIPAA Security Rule - Established national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

E. Health Information Technology for Economic and Clinical Health Act (HITECH) -

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

F. Protected Health Information –

Individually identifiable health information as described in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

- Created or received by a health care provider, health plan, employer or health care clearinghouse; or
- Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual.

Protected health information excludes information:

- In education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
- In records described at 20 USC 1232g(a)(4)(B)(IV);
- In employment records held by a covered entity in its role as employer; and
- Regarding a person who has been deceased more than 50 years.

G. Risk Analysis - The assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic protected health information held by a covered entity, and the likelihood of occurrence.

H. Risk Management - The actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic protected health information and to meet the general security standards.

Data Security Audit

The AdSS must develop policies and procedures to ensure the privacy of protected health information, the security of electronic protected health information, and breach notification to members [42 CFR 438.100(d) and 42 CFR 438.208(b)(4)].

The AdSS must have a security audit performed by an independent third party annually. If an AdSS performs in multiple AHCCCS lines of business, one comprehensive audit may be performed covering all systems for all lines of business or separate audits may be performed.

The audit must include, at a minimum, a review of the following:

1. Compliance with all security requirements as outlined in ACOM Policy 108, Attachment A, AHCCCS Security Rule Compliance Summary Checklist.

2. AdSS policies and procedures to verify that appropriate security requirements have been adequately incorporated into the AdSS's business practices, and the production processing systems. The AdSS's Policies and procedures must include the requirements for the Breach Notification Rule.

Audits performed in the second and subsequent years of the contract will focus primarily on remediation of prior findings and system and policy changes identified since the prior audit.

AHCCCS Security Compliance Report

The AdSS must submit the AHCCCS Security Rule Compliance Report to the Division annually as described in Section F3, Contractor Chart of Deliverables. The timeframe audited may be calendar year, fiscal year, or contract year and must be noted in the report. The report must include all findings detailing any issues and discrepancies between the AHCCCS Security Audit Checklist requirements and the AdSS's policies, practices and systems, and as necessary, a corrective action plan. In addition, the report must include written decisions regarding all addressable specifications.

The Division will verify that the required audit has been completed and the approved corrective action plan is in place and implemented as part of Operational Reviews.

The Division does not intend to release detailed audit reviews; however may, at its discretion, release a summary level of results.

AHCCCS Security Rule Compliance Checklist

A. Instructions

The AHCCCS Security Rule Compliance Checklist, located in the AHCCCS Operations Manual, identifies security rule requirements for administrative, physical, and technical safeguards. The Compliance Checklist must be signed and dated by the Chief Executive Officer or his/her designee verifying the information and must be submitted with the annual report.

B. Implementation Specifications

1. Required Specifications

If an implementation specification is identified as "required" (indicated with an "R" on the checklist), the specification must be implemented.

Addressable Specification: The concept of "addressable implementation specifications" was developed to provide covered entities additional flexibility with respect to compliance with the security standards. Addressable implementation specifications are indicated with an "A" on the checklist.

In meeting standards that contain addressable implementation specifications, a covered entity must do one of the following for each addressable specification:

a. Implement the addressable implementation specifications.

b. Implement one or more alternative security measures to accomplish the same purpose.

c. Not implement either an addressable implementation specification or an alternative.

The covered entity must decide whether a given addressable implementation specification is a reasonable and appropriate security measure to apply within its particular security framework. For example, a covered entity must implement an addressable implementation specification if it is reasonable and appropriate to do so, and must implement an equivalent alternative if the addressable implementation specification is unreasonable and inappropriate, and there is a reasonable and appropriate alternative. This decision will depend on a variety of factors, such as, among others, the entity's risk analysis, risk mitigation strategy, what security measures are already in place, and the cost of implementation.

The decisions that a covered entity makes regarding addressable specifications must be documented in writing. The written documentation should include the factors considered as well as the results of the risk assessment on which the decision was based.

2. Risk Analysis

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(A), for Risk Analysis, requires a covered entity to, *"conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity."*

Risk analysis is the assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic PHI held by a covered entity, and the likelihood of occurrence. The risk analysis may include taking inventory of all systems and applications that are used to access and house data, and classifying them by level of risk. A thorough and accurate risk analysis would consider all relevant losses that would be expected if the security measures were not in place, including loss or damage of data, corrupted data systems, and anticipated ramifications of such losses or damage.

3. Risk Management

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(B), for Risk Management, requires a covered entity to *"implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR. 164.306(a) [(the General Requirements of the Security Rule)]."* Risk management is the actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic PHI and to meet the general security standards.

4. Compliance Status

If the covered entity complies with the requirement, insert a "C" in the column. If the requirement is not met insert "NC" for non-compliant.

5. Compliance Documentation

List policies, procedures and processes used to determine compliance with the Implementation Specification.

109 INSTITUTION FOR MENTAL DISEASE 15 DAY LIMIT

REVISION DATE: 2/24/2021, 06/15/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

Purpose

This policy applies to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS). This policy establishes processes and AdSS requirements for compliance with managed care regulation 42 CFR 438.6(e), "Payments to MCOs for and Prepaid Inpatient Health Plans (PIHPs) for enrollees that are a patient in an institution for mental disease."

Definitions

A. Day - A calendar day unless otherwise specified.

B. Institution - An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services, to four or more persons unrelated to the proprietor.

C. Institution for Mental Disease (IMD) - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an institution for a mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010].

D. IMD Stay - The total number of calendar days of an inpatient stay in an institution for mental disease beginning with the date of admission through discharge, but not including the discharge date unless the member expires.

Policy

Medically necessary IMD Stays are covered for individuals under the age of 21 (except as noted below under "Members Turning 21 or 65 Years of Age") and for adults 65 years of age and older. For adult members age 21 and older but under the age of 65 (referred to in this policy as "adult member age 21-64"), coverage is subject to the limitations and requirements outlined in this policy. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services or settings at 42 CFR 438.3(e)(2)(i) through (iii).

In accordance with 42 CFR 438.6(e), IMD Stays are covered for adult members age 21-64, as long as the IMD Stay is no longer than 15 cumulative days during a calendar month.

The following provider types are considered to be IMDs subject to the limitations and requirements outlined in this policy:

A. B1-Residential Treatment CTR-Secure (17+Beds)

B. B3-Residential Treatment Center-Non-Secure

C. B6-Subacute Facility (17+Beds)

D. 71-Psychiatric Hospital

AdSS Requirements

A. Members remain enrolled and eligible for all medically necessary services during the entire IMD Stay whether the stay exceeds 15 cumulative days during a calendar month. The AdSS is responsible for the payment of these services.

B. For any IMD stay that exceeds 15 days, neither the IMD Stay nor any other medically necessary services provided during the length of that IMD Stay may be paid with Title XIX funding, including administrative funding for Title XIX services.

C. The AdSS responsible for behavioral health services shall complete and submit *ACOM 109 Attachment A – IMD Placement Exceeding 15 days* to the Division, within one business day of identification of an IMD Stay greater than 15 days.

D. Submission of Attachment A will result in a change to the member's physical and behavioral health enrollment/assignment with the AdSS resulting in an adjustment to the Capitation.

E. The AdSS shall continue to submit encounters for all medically necessary services including the IMD Stay, regardless of the length of the IMD Stay, and regardless if the Division recoups the capitation payment from the AdSS for that month; that is, the AdSS is not permitted to recoup payments to providers. The Division will use encounters to audit AdSS compliance with this policy. Encounters related to the IMD Stay will not be considered in the reconciliation and reinsurance processes.

F. The AdSS must maintain a network of providers adequate to provide members with adequate access to behavioral health services and ensure the member receives care in the setting most appropriate for the member's needs.

Capitation Recoupment

A. When an adult member's IMD Stay is longer than 15 cumulative days during the calendar month, the Division will recoup the AdSS entire monthly capitation payment for that member after recoupment from the Division by AHCCCS.

B. The change to a member's enrollment/assignment to non-Capitated will trigger the recoupment.

C. If two different AdSS are responsible for physical health services and behavioral health services for the member, the Division will recoup the entire monthly capitation payment from both AdSS after recoupment from the Division by AHCCCS.

D. The capitation recoupment will occur whether the AdSS pays the IMD.

E. This recoupment applies whether the member is dual eligible or the member has third party insurance coverage.

F. The AdSS will be notified of the contract type change/recoupment via the 834 and 820 files from the Division after receipt of same from AHCCCS.

G. After funds have been recouped between the Division and AHCCCS, the

Division will make a capitation payment to the AdSS(s) equal to a pro-rated amount of the monthly capitation payment for each day the member is not in an IMD during the calendar month.

Members Turning 21 Or 65 Years of Age

A. The IMD restriction does not apply for a member who is admitted prior to age 21 and turns 21 during the IMD Stay until the member turns 22 years of age during the IMD Stay. The AdSS is not required to report an IMD Stay greater than 15 days when the member is admitted prior to age 21 even if the member turns 21 during the same IMD Stay as long as the member is discharged prior to age 22.

B. For members who turn age 65 during an IMD Stay, all the days of the IMD Stay while the member is age 64 must be counted against the 15-day limit, and all the IMD Stay days when the member is 65 must not be counted against the limit.

The AdSS must report an IMD Stay greater than 15 days when the member is admitted prior to age 65, even if the member turns 65 during the same IMD Stay. After funds have been recouped between AHCCCS and the Division, the Division will make a capitation payment to the AdSS equal to a pro-rated amount of the monthly capitation payment for each day the member is age 65 or older during the IMD Stay.

110 MENTAL HEALTH PARITY

REVISION DATES: 2/16/22, 3/24/21
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, ACOM 110 Attachment A, AMPM 1020 Attachment F

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) whose contract includes this requirement and outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

DEFINITIONS

Aggregate Lifetime Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP).

Annual Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid in a fiscal year 12-month period under a MCO, PIHP, or PAHP.

Benefit Package - Benefits provided to a specific population group or targeted residents (e.g., individuals determined to have a serious mental illness) regardless of the Health Care Delivery System.

Cumulative Financial Requirements - Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.

Health Care Delivery System - The health care delivery system refers to the structure and organization of covered services and benefit packages available to AdSS members. Delivery systems can be fully integrated (all covered services administered by a single AdSS) or partially integrated (Members enrolled with an AdSS may receive covered services by multiple AdSS or via fee-for-service arrangements).

Medical/Surgical Benefits (M/S) - Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. Medical/surgical benefits include long-term care services.

Mental Health Benefits - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

Substance Use Disorder Benefits - Items or services for substance use disorders, as defined by the State and in accordance with applicable Federal and State law. Any disorder defined by the State as being or not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include long-term care services.

Treatment Limitations - Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

POLICY

A. MHPAEA Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the MHPAEA final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to Mental Health/Substance Use Disorder (MH/SUD) benefits than to Medical/Surgical (M/S) benefits. MHPAEA specifically:

1. Prohibits the application of annual or lifetime dollar limits to MH/SUD benefits unless aggregated dollar limits apply to at least one third of medical benefits;

2. Prohibits the application of financial requirements (e.g., copays) and Quantitative Treatment Limitations (QTLs) (e.g., day or visit limits) on MH/SUD benefits that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in that same classification; and

3. Prohibits the application of Non-Quantitative Treatment limits (NQTLs) (e.g., prior authorization) on MH/SUD benefits in any classification unless the NQTL, as written and in operation, is applied to the MH/SUD benefits comparably and no more stringently than to M/S benefits in the same classification.

B. Mental Health Parity Analysis Requirements

The AdSS are responsible for performing the initial and ongoing parity analyses. If some MH/SUD or M/S benefits are provided to members through another Health Care Delivery System, the AdSS are responsible for completing a parity analysis and submitting it to the Division. The Division is responsible for ensuring the AdSS are in compliance with this requirement.

1. Parity requirements apply to all MH/SUD benefits provided to members.

2. The parity analysis must be conducted and assessed at least annually and ongoing for events warranting a parity analysis as described below.

3. The parity analysis must be conducted for each benefit package regardless of Health Care Delivery System.

    a. The benefit package includes the covered services to ALTCS eligible members;

    b. A benefit package includes M/S and MH/SUD benefits, including long-term care benefits provided by the AdSS.

C. Standard Parity Requirements

1. Benefit Packages

    DDD AdSS benefit packages and Health Care Delivery Systems are defined as covered services available to children and adult members who are enrolled with the Division and ALTCS eligible, and Medicare cost sharing. Division members up to the age of 21 are designated as children for purposes of the benefit package.

    The AdSS shall adhere to all applicable established benefit packages and covered services when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

2. Defining MH/SUD and M/S Benefits

    MH/SUD benefits are items and services for MH/SUD conditions regardless of the type of AdSS or type of provider that delivers the item/service. The Division defines MH/SUD and M/S conditions using the ICD-10-Clincial Modification (ICD- 10). For purposes of parity, MH and SUDs are those conditions in ICD-10, chapter 5, “Mental, Behavioral and Neurodevelopmental Disorders,” sub-chapters 2-7 and 10- 11.

    a. Sub-chapter 1, “Mental Disorders Due to Known Physiological Conditions,” is excluded from the MH condition definition (and included in the M/S condition definition) because the physiological condition is primary for these diagnostic codes; and

    b. Similarly, sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the MH condition definition (and included in the M/S condition definition) because these are neurodevelopmental conditions, which are separate and distinct from mental and behavioral conditions, as indicated by the chapter title.

    AdSS shall utilize these definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, AdSS must apply the defined classifications outlined below.

In order to conduct the analysis, each service is assigned to one of four classifications: inpatient, outpatient, emergency care, and prescription drug. AdSSs shall apply the established benefit mapping when conducting the parity analysis. Refer to ACOM Chapter 100, Policy 110, Attachment A (AZ Parity Summary Benefit Package Mapping) for the benefit mapping.

Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

a. Inpatient: Includes all covered services or items provided to a member in a setting that requires an overnight stay including behavioral health placement settings;

b. Outpatient: Includes all covered services or items provided to a member in a setting that does not require an overnight stay, which does not otherwise meet the definition of inpatient, prescription drug, or emergency care services;

c. Emergency care: Includes all covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting; and

d. Prescription drugs: Covered medication, drugs, and associated supplies and services that require a prescription to be dispensed, which includes drugs claimed using the NCPDP claim forms.

Parity requirements for financial requirements, quantitative treatment limits, and non-quantitative treatment limits apply by classification (e.g., as inpatient, outpatient, emergency, and pharmacy).

AdSS shall apply the defined classifications when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

4. Testing MH/SUD Financial Requirements, Quantitative Limits, Annual Dollar Limits, and Non-Quantitative Treatment Limits.

a. When applicable, AdSS shall conduct limit testing as part of the initial arity analysis and shall re-assess compliance when changes may impact parity compliance. Testing limits includes:

i. Identifying and evaluating financial requirements and quantitative treatment limits using a 2-part, claims-based test (if applicable). The Division determined that the 2-part, claims-based test is not necessary when performing or overseeing the initial mental health parity.

ii. Identifying and testing aggregate lifetime and annual dollar limits (if applicable) using a multi-part claims-based test. The Division did not identify any of these limits applicable to any MH/SUD services and as a result, no review or testing is necessary.

iii. Identifying NQTLs and applying the NQTL information-based test to each NQTL.

a. Financial requirements include copays, coinsurance, deductibles, out of pocket maximums (does not include aggregate lifetime or annual dollar limits),

i. The AdSS must ensure that cumulative financial requirements (deductibles) do not accumulate separately for MH/SUD benefits.

ii. Individuals eligible for AHCCCS may be charged nominal copays, unless they are receiving a covered service that is exempt from copays or the individual is in a group that cannot be charged copays. Nominal copays are also referred to as optional copays. If a member has a nominal copay, then a provider cannot deny the service if the member states that the member is unable to pay the copay. There are specific populations that are exempt from any nominal copayments,

iii. During the initial mental health parity analysis (Contract Year 2017) and presently (Fiscal Year 2019), the Division requires all outpatient office visits in all benefit packages to have a copayment, with the exception of members and services exempted from copayments. Because all outpatient office visits have a copayment, the Division concluded without testing that these are the respective predominant limits. Similarly, for prescription drugs, a copayment applies to all prescription drugs for both M/S and MH/SUD conditions. This is considered the predominant limit, and

iv. The AdSS must adhere to Division Operations Policy 431 (Copayment) regarding copayment requirements, including the populations subject to a copayment, the amount of the copayment, populations and services exempt from copayments, as well as the out-of-pocket maximum.

b. Quantitative treatment limits are numerical limits on benefits based on the frequency of treatment, number of days, days of coverage, days in a waiting period, or similar limits on treatment scope or duration. In accordance with this Policy, the AdSS shall not apply quantitative treatment limits to any MH/SUD services in any classification in any benefit package, with the exception that hour limits currently applied to respite services (600 hours/year) and visit limits (15 visits per

Contract Year) currently applied to occupational therapy services in the outpatient classification are permissible under the parity requirements.

c. NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits.

i. Examples of NQTLs published in the Final MHPAEA Rule include:

1) Medical management standards (e.g., medical necessity criteria and processes or experimental/investigational determinations);

2) Prescription drug formulary;

3) Admission standards for provider network;

4) Standards for accessing out-of-network providers;

5) Provider reimbursement rates (including methodology);

6) Restrictions based on the location, facility type, or provider specialty;

7) Fail-first policies or step therapy protocols; and

8) Exclusions based on failure to complete a course of treatment.

ii. AHCCCS identified the following NQTLs as part of the initial MHPAEA compliance determination:

1) Utilization management NQTLs,

2) Medical necessity NQTLs,

3) Documentation requirements NQTLS, and

4) Out-of-network/geographic area coverage NQTLs.

iii. AdSSs shall not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the AdSS as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to M/S benefits in the classification, and

iv. Once NQTLs are identified, the AdSS shall collect and analyze information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL, in writing

and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis and AdSS Specific Requirements

1. The AdSS is responsible for administering a fully integrated contract and shall perform a parity analysis when there is a change in the AdSS' operations that may impact parity compliance including but not limited to:

   a. Changes to Financial Requirements (FRs) or QTLs;

   b. Changes to Benefit Packages, utilization requirements, covered services, or service delivery structures (i.e., change in the subcontractors performing administrative functions);

   c. Substantive changes to policies or procedures of the AdSS (or subcontractors performing administrative functions on the Division's behalf) that impact benefit coverage, access to care for provider contracting.

2. If the AdSS identifies any changes or deficiencies noted in the above, the AdSS is required to attach the Mental Health Parity analysis for those FR/QTLs and NQTLs impacted by the changes. Utilizing ACOM Policy 110 Attachment C and shall include:

   a. Any actual Parity issues identified,

   b. The FR/QTLs or NQTLs associated with the Mental Health Parity concern,

   c. The applicable Benefit Package (s) and affected classification(s),

   d. The nature of the Mental Health Parity compliance issue and the actions taken to address the parity issue.

3. AdSSs that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package shall perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis must be submitted to the Division as specified in the AdSS Contract with the Division.

4. The AdSS shall also report as specified in the AdSS Contract with the Division, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation applied no more stringently to MH/SUD Benefits than for M/S Benefits

5. In the event of a contract modification, amendment, novation, or other legal act changes which limits or impacts compliance with the mental health parity requirement, the AdSS shall conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the AdSS

shall provide documentation of how the parity requirement is met, with the submission of the contract change, and how sustained compliance will be achieved. The AdSS shall certify compliance with parity requirements prior to the effective date of the contract changes.

6. The AdSS shall report mental health parity deficiencies as specified in the AdSS' Contract with the Division and develop a corrective action plan to be in compliance within the same quarter as the submission.

7. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the AdSS' parity analysis.

8. The AdSS may utilize any data collection and documentation template for the parity analysis; however, the following elements must be clearly documented:

    a. Methodology, processes, strategies, evidentiary standards, and other factors applied.

    b. All financial requirements, AL/ADLs, QTLs and identified NQTLs AdSS must minimally report NQTL analysis results for prior authorization, concurrent review, medical necessity, outlier, documentation, and out of area criteria, but must also assess and document for the presence of other potential NQTLs:

        i. Monitoring mechanisms and aggregated results as applicable (e.g., denial rates);

        ii. Findings;

        iii. Components of the analysis that are determined to be non-compliant with parity along with a detailed plan to resolve identified deficiencies; and

        iv. The AdSS shall analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

9. If there have been no changes that affect the AdSS benefit package, utilization, or Health Care Delivery Systems, the AdSS shall submit to the Division an annual attestation (ACOM Policy 110, Attachment B, Mental Health Parity Attestation Statement) certifying ongoing compliance with mental health parity requirements as specified in the AdSS Contract with the Division.

10. The AdSS shall make available upon request to members and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. AdSSs shall also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

11. The AdSS may be required to respond to inquiries from the Division, AHCCCS or an AHCCCS contracted consultant. Inquiries may include AdSS policies and procedures requiring review to determine compliance with mental health parity regulations.

E. Division Oversight of AdSS Mental Health Parity

1. Each AdSS is required to send their Mental Health Parity reports to the Division for review. This will occur at a minimum annually and when changes are made as addressed in this policy.

2. The AdSS shall participate in an annual Operational Review conducted by the Division to ensure AdSS compliance with Mental Health Parity analyses, methodology, processes, and other related functions including, but not limited to:

    a. The AdSS policies and procedures for monitoring compliance with Mental Health Parity.

    b. The AdSS' completed analysis demonstrating compliance with Mental Health Parity as outlined in this policy.

    c. The AdSS' process when a deficiency is identified and the plan of how the AdSS will come back into compliance.

201 MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-22-201 et seq, A.A.C. R9-22-702, R9-22-705, R9-28-201 et seq, A.A.C. R9-29-101, A.A.C. R9-29-301 et seq, A.A.C. R9-29-302, A.A.C. R9-29-303

DELIVERABLES: AHCCCS Notification to Waive Medicare Part D Co-Payments

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to:

- Define cost sharing responsibilities for members who are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan.
- Maximize cost avoidance efforts by the AdSS and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

Definitions

A. Cost Sharing - The AdSS's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

B. Dual Eligible Medicare Beneficiaries (Duals) – A member who is eligible for the Division and both Medicaid and Medicare services. There are two types of Dual Eligible members: Qualified Medicare Beneficiary (QMB) Duals and Non-QMB Duals (Full Benefit Dual Eligible [FBDE], Specified Low Income Medicare Beneficiary [SLMB], QMB)

C. Full Benefit Dual Eligible (FBDE) - An AHCCCS member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.

D. In-Network Provider - A provider that is contracted with the AdSS to provide services.

E. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and local and Regional Preferred Provider Organizations (RPPOs).

F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.

H. Medicare Part D - Medicare prescription drug coverage.

I. Non-Qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in A.A.C. R9-29-101.

J. Out of Network Provider - A provider that is neither contracted with nor authorized by the AdSS to provide services to its members.

K. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB Dual person receiving both Medicare and Medicaid services and cost sharing assistance.

L. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

M. For QMB Duals and Non-QMB Duals, the AdSS's cost sharing payment responsibilities are dependent upon whether:

1. Service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid.

2. Services are received in or out of network (the AdSS only has responsibility to make payments to AHCCCS-registered providers).

3. Services are emergency services.

4. AdSS refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. R9-29-301 et seq.

An exception to the AdSS's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the AdSS must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For AdSS responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division's Operations Manual, Policy 434.

QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their AHCCCS Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C. 9-22 or A.A.C. 9-28 from a registered provider is not liable for any Medicare copayment, coinsurance, or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

AdSS Payment Responsibilities

A. The AdSS is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this policy (see Division Medical Policy Manual Chapter 300). These services include:

1. Chiropractic services for adults
2. Outpatient occupational and speech therapy coverage for adults
3. Orthotic devices for adults
4. Cochlear implants for adults
5. Services by a podiatrist
6. Any services covered by or added to the Medicare program not covered by Medicaid.

B. The AdSS only has responsibility to make payments to AHCCCS-registered providers.

C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the AdSS's network or prior authorization has been obtained.

D. The AdSS must have no cost sharing obligation if the Medicare payment exceeds the AdSS's contracted rate for the services. The AdSS's liability for cost sharing plus the amount of Medicare's payment must not exceed the AdSS's contracted rate for the service. There is no cost sharing obligation if the AdSS has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the AdSS must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS-registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS

QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST PAY:** *(Subject to the limits outlined in this policy)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: **a.** The Medicare copay, coinsurance or deductible, **or** b. The difference between the AdSS's contracted rate and the Medicare paid amount.

Figure 1 – QMB DUAL Cost Sharing - Examples

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *Subject to the limits outlined in this policy*			
	EXAMPLE 1	**EXAMPLE 2**	**EXAMPLE 3**
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100
Medicaid rate for Medicare service (AdSS's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
AdSS PAYS	**$20**	**$10**	**$50**

Non-QMB DUALS

A Non-QMB Dual eligible member who receives covered services under A.A.C. R9-22-201 et seq or A.A.C. R9-28-201 et seq from a provider within the AdSS's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22-201 et seq. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

AdSS Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-201 et seq, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: Non-QMB Duals (In Network)

NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST NOT PAY:**
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST PAY:** *Subject to the limits outlined in this Policy*
Medicaid Only	The provider in accordance with the contract
Both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): **a.** The Medicare copay, coinsurance or deductible, **or** b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (AdSS's contracted rate).

AdSS Payment Responsibilites (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracting provider the following applies (Table 3):

Table 3: NON-QMB Duals (Out of Network)

NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS** *Subject to the limits outlined in this Policy*
Medicare Only	Has no responsibility for payment.
Medicaid only and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the AdSS **has** referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the AdSS has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay the lesser of: **a.** The Medicare copay, coinsurance or deductible, **or** b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

Prior Authorization

The AdSS can require prior authorization. If the Medicare provider determines that a service is medically necessary, the AdSS is responsible for Medicare cost sharing if the member is a QMB Dual, even if the AdSS determines the service is not medically

necessary. If Medicare denies a service for lack of medical necessity, the AdSS must apply its own criteria to determine medical necessity. If criteria support medical necessity, the AdSS must cover the cost of the service for QMB Duals.

Part D Covered Drugs

For QMB and Non-QMB Duals, federal and state laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.

203 CLAIMS PROCESSING

REVISION DATE: 11/8/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2903.01(G); 36-2904.G; 42 § C.F.R. 438.242(a); 45 §§ C.F.R. 160.101 et seq., 162.100 et seq. and 164.102 et seq.; AHCCCS Contract; Section F3 Contractor Chart of Deliverables

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Administrative Services Subcontract" means a contract that delegates any of the requirements of the Division's contract with AHCCCS.
2. "Clean Claim" means a claim that may be processed without obtaining additional information from the Provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and

Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.

4. "Member" means the same as "client" as defined by A.R.S. § 36-551.
5. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
6. "Receipt Date" means the day a claim is received at the AdSS's specified claim mailing address or received through direct electronic submission to the AdSS's electronic claims processing system or received by the AdSS's designated clearinghouse.
7. "Subcontractor" means one of the following:
    a. A Provider of health care who agrees to furnish covered services to Members; or
    b. A person, agency or organization with which the AdSS has contracted or delegated some of its management/administrative functions or responsibilities; or

c. A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Division agreement.

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The AdSS shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. These AdSS shall ensure that claims processes and systems generate information pertaining to the following areas:
   a. Service utilization;
   b. Claim disputes;
   c. Member grievances and appeals; and
   d. Disenrollment for reasons other than loss of Medicaid eligibility.

3. The AdSS shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:
    a. The AdSS subcontract;
    b. The AdSS Provider manual;
    c. The AdSS website; or
    d. Other Provider platforms.
4. The AdSS shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date the claim is electronically received by the AdSS.

B. CLAIM TIMELY FILING, PAYMENT, AND REPORTING REQUIREMENTS

1. The AdSS shall adjudicate claims for each form type as follows, unless a subcontract specifies otherwise:
    a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and
    b. 99% of all Clean Claims within 60 days of receipt of the Clean Claim.

2. The AdSS shall ensure 95% of Clean Claims reach paid status on a Provider's first billing submission.
3. The AdSS shall ensure less than 20% of a Provider's second submission of claims are denied.
4. The AdSS shall submit a report to the Division with the following Clean Claim payment or claim payment denial information monthly:
    a. Percentage of Clean Claims that reach paid status on a Provider's first billing submission.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the paid status percentage of Clean Claims falls below the contract performance minimum of 95%.
    b. Percentage of claims that are denied, calculated by dividing the total number of claims denied in the month by the total number of claims processed in the month.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the total

percentage of denied claims reported is above 20%; or

ii. The AdSS shall highlight the appropriate field in the report and provide an explanation if there is a 15% increase of denied claims from the previous reporting month.

5. The AdSS shall refer to Attachment B of the DDD Claims Dashboard Reporting Guide for additional reporting guidelines.
6. The AdSS shall not pay claims
   a. Initially submitted more than six months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
   b. Claims submitted as Clean Claims more than 12 months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.
7. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization

(MCO), when one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

8. If the Provider submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:
   a. 60 days from the date of the recoupment;
   b. 12 months from the date of service; or
   c. 12 months from the date that eligibility is posted; whichever date is later.
9. The AdSS shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes listed in item 7 of this section.
10. The AdSS shall adhere to claim payment requirements that pertain to both contracted and non-contracted Providers.

C. DISCOUNTS

1. The AdSS shall apply a quick pay discount of 1% on acute hospital inpatient, outpatient, and freestanding emergency

department claims paid within 30 days of the date on which the Clean Claim was received.

2. The AdSS shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS

1. The AdSS shall pay interest on late payments and report the interest as directed in the Division Encounter Manual and the DDD Claims Dashboard Reporting Guide.
2. The AdSS shall pay slow payment penalties or interest on payments made after 60 days of receipt of the hospital Clean Claim as follows:
    a. The AdSS shall pay interest at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.
    b. The AdSS shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding

emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The AdSS shall pay interest on payments made after 30 days of receipt of a Clean Claim for authorized services submitted by a licensed skilled nursing facility as follows:
   a. At the rate of 1% per month; and
   b. Prorated on a daily basis from the date the Clean Claim is received until the date of payment.
4. The AdSS shall, for non-hospital Clean Claims, pay interest on payments made after 45 days of receipt of the Clean Claim as follows:
   a. At the rate of 10% per annum; and
   b. Prorated daily from the 46th day until the date of payment.
5. The AdSS shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission, not the claim dispute.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The AdSS shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or their assigned representative interested in and capable of electronic submission of:
    a. Eligibility verifications;
    b. Claims;
    c. Claims status verifications; and
    d. Prior authorization requests; or
    e. The receipt of electronic remittance.
2. The AdSS shall make claim payments via electronic funds transfer (EFT).
3. The AdSS shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The AdSS shall generate an electronic remittance advice advice related to the payments or denials to Providers that includes at a minimum:
    a. The reasons for denials and adjustments;

b. A detailed explanation or description of all denials and adjustments;

c. The amount billed;

d. The amount paid;

e. Application of coordination of benefits (COB) and copays;

f. Providers rights for claim disputes;

g. Detailed instructions and timeframes for the submission of claim disputes and corrected claims; and

h. A link or supplemental file where claims dispute or corrected claims submission information is explained.

2. The AdSS shall send the electronic remittance advice with the payment, unless the payment is made by EFT.

3. The AdSS shall send any remittance advice related to an EFT to the Provider no later than the date of the EFT.

G. GENERAL CLAIMS PROCESSING REQUIREMENTS

1. The AdSS shall use nationally recognized methodologies to correctly pay claims, including:

a. National Correct Coding Initiative for professional, ambulatory surgery centers, and outpatient services;
b. Multiple procedure or surgical reductions; and
c. Global day evaluation and management bundling standards.

2. The AdSS shall ensure that the claims payment system assess and apply data-related edits including:
   a. Benefit package variations,
   b. Timeliness standards,
   c. Data accuracy,
   d. Adherence to Division and AHCCCS policy,
   e. Provider qualifications,
   f. Member eligibility and enrollment, and
   g. Overutilization standards.
3. The AdSS shall, if a claim dispute is overturned in full or in part, reprocesse and pay the claim(s):
   a. In a manner consistent with the decision; and
   b. Within 15 business days of the decision.

4. The AdSS claims payment system shall not require a recoupment of a previously paid amount when:
    a. The Provider's claim is adjusted for data correction, excluding payment to a wrong Provider; or
    b. An additional payment is made.
5. The AdSS shall submit encounters in accordance with Division and AHCCCS standards and thresholds.
6. The AdSS shall adhere to the following requirements when processing claims:
    a. COB and third party liability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual;
    b. Claims processing requirements per contract and the DDD Claims Dashboard Reporting Guide;
    c. Claims recoupments and refunds requirements per contract, Division Operations Policy 412, and the DDD Claims Dashboard Reporting Guide; and

d. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 C.F.R. §§ Parts 160, 162, and 164.

5. The AdSS, when cost avoiding a claim, shall apply the following payment provisions:

a. Claims from Providers contracted with the AdSS: The AdSS shall pay the difference between the AdSS contracted rate and the primary insurance paid amount, not to exceed the AdSS contracted rate.

b. Claims from Providers not contracted with the AdSS: The AdSS shall pay the difference between the AHCCCS capped-fee-for-service rate and the primary insurance paid amount, not to exceed the AHCCCS capped-fee-for service.

H. CLAIMS PROCESSING BY THE AdSS

1. The AdSS shall request prior approval from the Division for obtaining subcontracts for claims processing to be performed by or under the direction of a subcontractor.

2. The AdSS shall remain responsible for the complete, accurate, and timely payment of all valid Provider claims arising from the provision of medically necessary covered services to its enrolled Members regardless of administrative service arrangements.
3. The AdSS shall forward all claims received to the subcontractor responsible for claims adjudication.
4. The AdSS shall require the subcontractor that processes claims to submit a monthly claims aging summary to the AdSS to monitor compliance with claims payment timeliness standards.
5. The AdSS shall monitor the payment processing subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.
6. The AdSS shall, upon completing the formal performance review of the payment processing subcontractor:
    a. Communicate any performance deficiencies resulting from the review to the subcontractor;
    b. Establish a corrective action plan that addresses the deficiencies; and

c. Provide the results of the performance review and the correction plan to the Division upon completion.

7. The AdSS shall monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.

205 GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT REQUIREMENTS FOR NON-CONTRACTED PROVIDERS

EFFECTIVE DATE: October 1, 2019

Purpose

This Policy applies to the Division of Developmental Disabilities Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide ground ambulance transportation reimbursement requirements. It is limited to AdSS and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Definitions

For purposes of this policy the following definitions apply:

A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS as either transportation by ground ambulance vehicle, that has medically necessary supplies and services, and the treatment includes administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one ALS procedure:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line.

B. Ambulance - Ambulance as defined in A.R.S. §36-2201.

C. Basic Life Support (BLS) - Transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as described in 42 CFR 414.605.

D. Emergency Ambulance Services - Emergency ambulance services are as described in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

E. Emergency Ambulance Transportation - Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility.

F. Emergency Medical Care Technician (EMCT) - As defined in A.A.C. R9-25-101(18).

G. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

H. Emergency Medical Services - Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

Policy

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by AHCCCS at a percentage, prescribed by law, of the Ambulance provider's ADHS-approved fees for covered services. These rates are contained in the AHCCCS Capped Fee for Service (FFS) Fee Schedule for Certificate of Necessity Providers and are used by the AdSS for reimbursement when no contract exists with the provider.

For Ambulance providers, whose fees are not established by ADHS, and no contract exists with the provider, the AHCCCS Capped FFS Fee Schedule is for Ground Transportation are used by the AdSS.

Emergency Ground Ambulance Claims are Subject to Medical Review

Claims are submitted with documentation of medical necessity and a copy of the trip report evidencing:

A. Medical condition, signs, symptoms, procedures, and treatment.

B. Transportation origin, destination, and mileage (statute miles).

C. Supplies

D. Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial. The AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

Criteria and Reimbursement processes for Advanced Life Support (ALS) and Basic Life Support

A. Advanced Life Support (ALS) level

1. To reimburse Ambulance services at the ALS level, all the following criteria must be satisfied**:**

a. The Ambulance must be ALS licensed and certified in accordance with A.R.S. §36**-**2202, A.R.S. §36**-**2204, and A.R.S. §36**-**2212.

b. Emergency Medical Care Technician (EMCT) are present and EMCT services/procedures are medically necessary, based upon the member's symptoms and medical condition at the time of the transport.

c. EMCT services/procedures and authorized treatment activities were provided.

B. Basic Life Support (BLS) level

1. To reimburse Ambulance services at the BLS level, all the following criteria must be satisfied:

a. The Ambulance must be BLS licensed and certified in accordance with A.R.S.§36-2212 and A.A.C. R9-25-201.

b. EMCT are present

c. EMCT services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport.

d. EMCT services/procedures and authorized treatment activities were provided.

Claims submitted without such documentation are subject to denial. The AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

Non-Emergent Ground Ambulance Transportation Payment Provisions

A. Non-emergent Ambulance transportation is subject to review for medical necessity by the AdSS. Medical necessity criteria are based on the medical condition of the member. Non-emergent transportation by an ambulance is appropriate if:

1. Documentation supports that other methods of transportation are contraindicated.

2. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

Non-emergent transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the AdSS discretion, non-emergent ambulance transport may not require prior authorization or notification. This may include after-hours calls. An example is an ambulance company which receives a call from the emergency room to transport a nursing facility member back to the facility and the AdSS cannot be reached.

All hospital-to-hospital transfers are paid at the BLS level unless the transfer meets ALS criteria. This includes transportation between general and specialty hospitals.

C. Transportation reimbursement is adjusted to the level of the appropriate alternative transportation when circumstances do not necessitate an ambulance transport, or the services rendered at the time of transport are deemed not medically necessary. Ambulance

providers that have fees established by ADHS are reimbursed in accordance with A.R.S. § 36-2239(H).

Refer to AMPM Policy 310-BB for additional requirements for coverage of transportation.

305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155
DELIVERABLES: Performance Bond or Bond Substitute, ACOM 305 Attachment A

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this Policy is to establish standards to meet the performance bonding and equity per member requirements. These standards will continue to ensure an AdSS ability to meet its claims payment obligations, while addressing the individual differences among AdSS and enrollment growth.

Definitions

A. Equity - Net Assets that are not designated or restricted for specific purposes.

B. Performance Bond - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

C. Surety Bond - An agreement between the Division, the AdSS, and the Surety where the surety provides a financial guarantee to the Division.

Policy

The Division requires the posting of a Performance Bond or Bond Substitute in addition to the initial minimum capitalization and equity per member requirements as described below. This is to guarantee payment of the AdSS obligations under the Contract including, but not limited obligations or payments to providers and non-contracting providers and any other entity that subcontracts for the performance of the AdSS obligations under this Contract whether related to coverage for services to members or for the administration of this Contract.

The Division will inform the AdSS of the required initial amount of the Performance Bond or Bond Substitute, as determined by the Division, prior to or at the beginning of each contract cycle. This requirement must be satisfied by the AdSS no later than 30 days after notification by the Division of the initial amount required.

After the initial performance bond or Bond Substitute is satisfied, the Division will evaluate each AdSS enrollment statistics and/or monthly capitation payments and determine if adjustments are necessary in accordance with this Policy.

Annually on October 1, the AdSS provides a written attestation, consistent with 42 C.F.R. 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful. See Attachment A.

Performance Bond Requirements and Bond Substitutes

A. The Performance Bond must be in a form acceptable to the Division as described in Section III B of this Policy. The AdSS must request an approval from the Division before a Bond Substitute is established.

B. The AdSS must not change the amount, duration, scope, or type of the performance bond of Bond Substitute without prior written approval from the Division's Finance unit.

C. The AdSS must not pledge any Bond Substitute as collateral or security for any other loan, debt, or obligation of the AdSS or pledge the Bond Substitute as security to creditors.

D. The Performance Bond or Bond Substitute maintains after the contract term until outstanding and contingent liabilities greater are less than $50,000, or 15 months following the termination date of the contract with the Division, whichever is later and will be in the amount and for the term determined by the Division.

E. Any security agreement must be disclosed.

F. An AdSS that fails to maintain or renew the Performance Bond or Bond Substitute as required by the Contract with the Division and as outlined in this Policy, is considered in material breach of the Contract with the Division.

G. Following a merger/acquisition of an AdSS or an AdSS parent company, the Division reserves the right to require additional Performance Bond assurances on behalf of the new entity, including, but not limited to, expanding the Performance Bond or Bond Substitute to include service dates prior to the merger/acquisition.

H. In the event of a default by the AdSS, the Division will, in addition to any other remedies it may have under the Contract, obtain payment under the Performance Bond or Bond Substitute to remedy the breach, including but not limited to one or more of the following purposes:

1. Paying any damages sustained by providers, and other subcontractors because of a breach of the AdSS obligations under this Contract.

2. Reimbursing the Division for any payments made by the Division on behalf of the AdSS.

3. Reimbursing the Division for any administrative expenses incurred because of a breach of the AdSS obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract. Terminations pursuant to Section E, Termination for Convenience, of the Contract do not require reimbursement to the Division for administrative expenses.

4. Reimbursing expenditures incurred by the Division in the direct operation of the AdSS under Section E.

5. Paying any sanctions imposed under Section D, to the extent the sanctions

are not offset against payments due from the Division to the AdSS as provided for under Section G2, Right of Offset of the Contract.

Performance Bonds and Types of Bond Substitute

A. Performance Bond

1. Establishment of Bond

a. The AdSS must send a copy of the completed Performance Bond form to the Division's Finance Department, 30 days prior to the execution of the bond agreement. The Division will review the agreement and advise the AdSS in writing of the acceptance of the Performance Bond form to be executed or that changes are necessary. The Division review will only be for the sufficiency of the agreement to meet the Division Performance Bond requirements section.

b. Performance Bond Form includes the following requirements

i. Issued by a Surety

ii. The Performance Bond must be in an amount that meets or exceeds the Performance Bond dollar requirement.

iii. The Performance Bond guarantees performance by the AdSS for all obligations, including post-award obligations that precede the beginning of the first contract year and "wind down" obligations that follow termination of the contract.

iv. The Performance Bond includes a statement that the Performance Bond cannot be changed in the amount, duration, or scope or discontinued without the written authorization of the Division Finance Department. Any changes in the Surety or the terms of the Performance Bond is approved in writing by the Division Finance Department at least 30 days prior to the anticipated change date.

v. The Performance Bond includes a contact person at the financial institution issuing the Performance Bond and a contact phone number.

2. After the Performance Bond Form is executed, the Division sends the original completed Performance Bond Form to the Division Finance Department signed, and notarized by the AdSS and the Surety.

3. The Division will hold the original Performance Bond Form in safe keeping until the agreement ends or is terminated by the parties.

4. The AdSS is not required to submit a separate Surety Bond to support the Performance Bond Form. If a supporting Surety Bond exists, to the extent the

terms of a Surety Bond conflict with the terms of the Performance Bond Form, the terms of the Performance Bond Form are controlling.

5. Return of Performance Bond Form original

The original Performance Bond Form will be returned to the originators upon:

a. The later of 15 months after the termination of the Contract or when the AdSS actual and contingent liabilities after the termination of the Contract are less than $50,000.

b. Satisfying the Performance Bond requirement with a Bond Substitute(s) as outlined and approved by the Division.

B. Types of Bond Substitutes

With the prior written approval of the Division Finance Department, the AdSS may provide one or more of the following Bond Substitutes in lieu of a Performance Bond:

Cash Deposits, Irrevocable Letter of Credit, Certificate of Deposit, and any other type of security agreed to by the Division.

C. Cash Deposit

1. Deposit of Funds

a. Any funds to be deposited with the State Treasurer must be sent to the Division in the form of a check or a wire transfer of funds to the State Treasurer. Reference *ACOM 305 Attachment A Instructions for Wire/ ACH Transfers of Funds to AHCCCS via Arizona State Treasurer*.

b. Additionally, a letter should be sent to the Division describing:

i. The application of funds

ii. A contact person at the AdSS and contact phone number, for any issues concerning the deposit, and a wire number if the funds were sent via a bank wire.

c. The Division will "claim" the funds by submitting a copy of the AdSS letter and a "Securities Safekeeping" form to the State Treasurer's Office. After the funds, have been claimed, the Division will send a confirmation that the funds were received and claimed.

2. Withdrawal of Funds

a. To withdraw principal funds, send a letter to the Division requesting the withdrawal. The letter must include:

i. The amount of the withdrawal

ii. The program from which the funds are being withdrawn

iii. The date that the funds should be withdrawn (allow a minimum of 10 working days)

iv. The manner the warrant from the State Treasurer's office is to be handled:

- Mailed by the US Postal Service
- Courier pick-up (please include a phone number of the primary contact so prompt notice can be given)
- Wiring instructions.

b. The Division will submit to the State Treasurer's Office a copy of the AdSS letter and a "Securities Safekeeping" form to release the funds. The Division will forward the warrant to the AdSS in the manner requested in the withdrawal letter.

D. Irrevocable Letter of Credit

1. Establishment of Irrevocable Letter of Credit

a. Before a Letter of Credit can be accepted in lieu of performance bond it must be approved by the Division for form and amount. Requirements include:

i. Be of standard commercial scope and issued by a bank, insured by the Federal Deposit Insurance Corporation, credit union insured by the National Credit Union Administration or savings and loans association insured by Federal Savings and Loan Insurance Corporation and authorized to do business in the State of Arizona.

ii. For an amount that meets or exceeds the Bond Substitute dollar requirement.

iii. Payable to the Division for the benefit of covered members, providers and certain third parties

iv. A statement that the Letter of Credit cannot be changed in the amount, duration, or scope, or discontinued without the written authorization from the Division.

b. The AdSS must send a copy of the Letter of Credit to the Division Finance Department to 30 working days prior to the execution of the Letter of Credit. The Division will review the Letter of Credit and advise the AdSS in writing whether it is accepted or that changes are necessary including but not limited to, expiration date and amount. The Division review will only be for issues that are necessary for the

Division Letter of Credit. It will not include review for any other matters.

c. After the agreement is executed, the AdSS must send the original to the Division. The original will be held in safe keeping until the agreement ends or is terminated by the parties.

d. The AdSS must send notification of a contact person at the financial institution issuing the letter of credit and contact phone number to the Division Finance Manager.

2. Return of the original Letter of Credit

The original Letter of Credit will be returned to the originators upon:

a. Termination of the Letter of Credit

b. Termination of the Division Contract

c. Satisfying the Performance Bond or Bond Substitute requirement with another acceptable form as outlined by the Division.

Certificate of Deposits

Certificates of Deposit are acceptable only by a bank, savings and loan, or credit union that is insured by the appropriate Federal institution.

A. Types of Certificate of Deposits

1. Only Certificates of Deposit from banks

2. Savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the performance bond.

B. Assignment to Arizona State Treasurer

C. All Certificates of Deposit must be assigned to the Arizona State Treasurer in compliance with A.R.S. §35-155. Division finance personnel completes this by submission of the "Assignment to Arizona State Treasurer" form.

D. Deposit of the Certificate of Deposit.

1. The AdSS must send or deliver the original Certificate of Deposit (or receipt for the Certificate of Deposit if a certificate is not issued) and the Assignment form to the Division. A letter should accompany the Certificate of Deposit describing the contract or line of business (e.g., Acute Care, DDD, CRS, ALTCS/EPD, or MA) the Certificate of Deposit is satisfying and a contact person.

2. After the Certificate of Deposit has been sent to the State Treasurer, the Division will send a copy of the State Treasurer's "Securities Safekeeping" form to the Treasurer to record the deposit of the

Certificate of Deposit.

3. After the Certificate of Deposit has been deposited with the State Treasurer, the AdSS must monitor the maturity date. No notification should be expected from the State Treasurer's office or the Division. Evidence of the renewal of each CD must be sent to the Division within five business days prior to the renewal date.

4. The AdSS must send notification of a contact person at the AdSS and contact phone number to the Division Finance Manager.

E. Withdrawal of a Certificate of Deposit

The AdSS must send a letter to the Division requesting the release of a specific Certificate of Deposit providing:

1. The name of the institution that issued the Certificate of Deposit

2. The certificate number

3. The amount of the Certificate of Deposit

4. The programs from which the Certificate of Deposit is being withdrawn

5. The manner the Certificate of Deposit is to be returned to the Plan

6. A contact person.

The Division submits to the State Treasurer's Office a copy of the AdSS letter and a "Securities Safekeeping" form to release the funds. The Division forwards the warrant to the AdSS in the manner requested in the withdrawal letter.

F. Any Other Type of Substitute Securities

1. The Division may accept a substitute security or securities in lieu of the surety bond or bond substitute forms discussed above. The AdSS must obtain prior approval from AHCCCS for any Substitute Securities.

   a. The AdSS agrees to perform all acts and execute any and all documents including, but not limited to, security agreements and necessary filings pursuant to the Arizona Uniform Commercial Code, necessary to grant the Division an enforceable security interest in such substitute security to secure performance of the AdSS obligations under the Contract.

   b. The AdSS is solely responsible for establishing the credit-worthiness of all forms of substitute security.

2. The Division may, after written notice to the AdSS, withdraw its permission for a substitute security or securities, in which case the AdSS must provide the Division with Performance Bond or an alternate form of Bond Substitute

discussed above.

Performance Bond and Bond Substitute Requirement for a Terminated AdSS

A. The Performance Bond or Bond Substitute amount must be maintained after the contract term in an amount sufficient to cover the Terminated AdSS outstanding and contingent liabilities greater than $50,000, or 15 months following the termination date of their contract, whichever is later, to guarantee payment of the AdSS obligations to providers, non-providers, and other subcontractors and performance by the AdSS of its obligations under the Contract with the Division.

B. The Performance Bond or Bond Substitute must be in a form acceptable to the Division.

C. Annually, on October 1, the AdSS must provide a written attestation, consistent with 42 C.F.R. ~~§§~~ 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful.

D. A terminated AdSS may request a reduction in the Performance Bond or Bond Substitute amount sufficient to cover all outstanding liabilities, including liabilities greater than $50,000, subject to the Divisions' approval. A Terminated Contractor AdSS may not change the amount, duration, scope, or type of the Performance Bond or Bond Substitute without prior written approval from the Division Finance. Any modification in the Performance Bond or Bond Substitute must be approved by the Division Finance at least 30 days before the revision of the Performance Bond or Bond Substitute has been executed.

Equity per Member Requirements

A. Formula

Unrestricted equity, less on-balance sheet performance bond or bond substitute, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted by the Division, divided by the number of members enrolled at the end of the period.

B. Requirement

CYE2020: At least $450 per member

CYE2021: At least $500 per member

CYE2022 and thereafter: At least $500 per member

C. Division Certified Medicare Advantage Plan Requirement:

$350 per member upon commencement of the plan.

Remediation When an AdSS Fails to Meet the Equity per Member Requirement

If an AdSS equity per member falls below the requirement, the Division will review the

causes for the lack of compliance. The Division may require the AdSS to comply with one or more of the following measures:

A. Capital infusion, within 30 days of non-compliance, in an amount sufficient to not only bring equity into compliance, but also to maintain compliance.

B. Submission of corrective action plan to increase equity

C. Monthly financial reporting, if not already required

D. Increase the amount of the Performance Bond or Bond Substitute

E. Sanctions and/or Enrollment Cap, if applicable.

If the AdSS fails to comply with the above requirements, the Division may apply sanctions as delineated in *AdSS Operations Manual, Policy 408*.

Restrictions on Equity

The following asset types will constitute restricted assets, and therefore will be subtracted from AdSS equity when calculating the equity per member ratio:

A. Assets recorded as "due from affiliates." The AdSS may request a waiver from the Division to include the prorated portion of the due from affiliates balance resulting from Division approved cash/bank account sweep arrangements.

B. Goodwill and adjustments to other assets resulting from a purchase, including those resulting from purchases and revaluations recorded in accordance with FASB Accounting Standards Codification Topic 105 - Generally Accepted Accounting Principles and FASB Accounting Standards Codification Topic 350 - Intangibles — Goodwill and Other

C. Guarantees of debt, pledges, and assignments.

D. On balance sheet Performance Bonds or Bond Substitute

E. Other assets determined to be restricted by the Division.

Requirements for AdSS with Restricted Equity

If AdSS equity is not supported by unrestricted cash or investments, and the AdSS does not meet the equity per member requirements, then the AdSS may be required to maintain a Performance Bond or Bond Substitute in an amount greater than 100% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

Fund Balance and Capitalization Requirements

If the AdSS equity becomes a fund deficit, the AdSS and its owners must fund the deficit through capital contributions in a form acceptable to the Division. The capital contributions must be for the period in which the deficit is reported and must occur within 30 days of the financial statement due to the Division. The Division at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. The Division may,

at its option, impose enrollment caps ~~and~~/or sanction the AdSS because of an accumulated deficit, even if unaudited.

Division Monitoring Responsibilities

A. The Division's Finance Unit monitors compliance with equity per member requirements on a quarterly basis. Analyses will be performed to determine the equity per member. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will be required to submit a plan to increase the equity and/or capitalization within 30 days.

B. The Division's Finance Unit monitors compliance with Performance Bond or Bond Substitute requirements on a monthly basis. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will have 30 days to comply with new requirements.

307 ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE-BASED PAYMENTS INCENTIVE

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 306, ACOM Policy 307, Attachments A and B

DELIVERABLES: Alternative Payment Model (APM) Strategies Certification (Final), Structured Payment File, and APM indicator; Alternative Payment Model APM Strategies Certification (Initial)

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this Alternative Payment Model (APM) Initiative is to encourage AdSS activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the AdSS and provider through APM strategies.

Definitions

A. Alternative Payment Model Strategies (In LAN-APM Category Order) - A model that aligns payments between payers and providers to incentivize quality, health outcomes and value over volume, to achieve the goals of better care, smarter spending, and healthier people.

The APM strategies discussed in this initiative originate from the Learning Action Network APM Framework (LAN-APM), which include the following categories and strategies:

- Fee-For-Service – No Link To Quality & Value
- Fee-For-Service – Link To Quality & Value (Foundational Payments for Infrastructure & Operations, Pay for Reporting, Pay for Performance)
- APMs Built on Fee-For-Service Architecture (APMs with Shared Savings, APMs with Shared Savings and Downside Risk)
- Population Based Payment (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance & Delivery Systems).

See ACOM Policy 307, Attachment A to view the LAN-APM strategies.

B. Pay for Performance - Purchasing strategy in which providers are rewarded for performing well on quality metrics. It can also include penalties for providers who do not perform well on quality metrics. In this strategy, specific providers are responsible for the cost and quality associated with a particular set of procedures or services. Payments are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures.(LAN-APM Category 2C).

C. APMs Built On Fee for Service Architecture (LAN-APM Category 3)

1. APMS with Shared Savings - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A).

2. APMs with Shared Savings and Downside Risk - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B).

D. Population Based Payment (LAN-APM Category 4)

1. Condition-Specific Population-Based Payment - Purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes per member per month payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN- APM Category 4A).

2. Integrated Finance and Delivery Systems - Purchasing strategy of prospective, population-based payments structured to encourage providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C).

3. Encounter - For the purposes of this policy, all encounters must be in an adjudicated and approved status.

4. Performance Based Payment - A payment from an AdSS to a provider upon successful completion, or expectation of successful completion, of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment usually occurs after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

General

The AdSS must meet the APM strategies qualifying criteria in in "A" and "C" of AdSS Responsibilities (below), and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in

AdSS Responsibilities

A. A minimum percentage of total Title XIX payments (both APM and non-APM, whether contracted or non-contracted), must be governed by APM strategies for the contract year.

The Division intends that the minimum value threshold will grow each year according to the schedule below.

	DDD Choice Plan
CYE 19 Anticipated	35%
CYE 20 Anticipated	50%
CYE 21 Anticipated	60%

Strategies for this initiative may not include:

- Block Purchase Payment Arrangement Methodology with no link to quality and value
- Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1)
- Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A).

Strategies that incorporate the Pay for Reporting strategy (LAN-APM Category 2B) are considered by the Division to meet the qualifying criteria on a case-by-case basis, and prior approval is required:

- The Division only considers approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally used for APM arrangements.
- The Division expects to consider approval only on a short-term basis.

Strategies used must meet the definitions provided in the Definitions section of this policy. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

AHCCCS will have a requirement beginning in CYE19 for specific usage of strategies in LAN-APM Categories 3 and 4; this information will be determined based upon a review of contractor deliverables and will be released in a Public Notice published in or after January 2018. AHCCCS intends that the required percentage of strategies in LAN-APM Category 3 and Category 4 grow each year.

The AdSS is responsible for identifying which strategy applies to each APM contract and whether each contract applies to a limited cost of care, where the provider can only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members' total medical costs and only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars must not be counted under multiple contracts. Additionally, one contract must not be counted under multiple strategies.

The AdSS may use quality measures other than the measures identified in this policy as part of the AdSS's APM strategies.

To count towards meeting the qualifying criteria, strategies must be evidenced by written contracts. For those contracts executed before February 1 of each contract year, the Division counts the strategies for the time period in the contract year for which the contract is in effect. For those contracts executed after February 1 of each contract year, the Division counts the strategies for the time period from the execution date forward for which the contract is in effect.

B. The AdSS must certify to the Division that these requirements will be met, by submitting an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in below under "Structured Payment File and Post Adjudicated/Post Submitted File."

1. An initial APM strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager within 60 days of the start of the contract year, and

2. A final APM Strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager, and the Structured Payment File, due 270 days after the end of the contract year.

   The Division will submit the APM Strategies Certifications on behalf of the AdSSs.

   In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

Failure to certify to the APM strategies qualifying criteria in a particular contract year will result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions listed under General (above)

The Division reserves the right to request an audit of the Certifications included in ACOM Policy 307, Attachment B. The AdSS, upon the request of the Division, must provide documentation of APM contracts and payments to providers for performance based payments.

Division Responsibilities

A. The performance-based payments made by the AdSS to providers will be paid by the Division through a lump sum payment through a future monthly capitation payment. Upon receipt and review of the final APM Strategies Certification discussed in AdSS Responsibilites, The Division will perform testing of the performance-based payment amounts reported by the AdSS prior to payment of the incentive, including review of AdSS documentation of APM contracting and payments to providers for performance-based payments. The performance-based payment incentive will be adjusted for premium tax.

The AdSS must report the performance-based payments on an accrual basis. The Division reserves the right to perform a look-back and true-up of the previous year's accrual in a subsequent year's payment.

B. For any APM contract that is effective for a period other than the measurement year, The Division will allow performance-based payments to be included in the year to which the lump sum performance-based payments incentive is attributable. For example, a contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X lump sum payment and six months (October 1, 201X – March 31, 201Y) in the 201Y lump sum payment.

The AdSS is not required to meet the APM strategies qualifying criteria in AdSS Responsibilites in order for the performance-based payments incentive to be paid to the AdSS.

The Division will test the total amount of performance-based payments incentive due to the AdSS to ensure that the federal limit of 5% of annual prospective gross capitation is met. Any amount over the limit must be reduced to bring the final due payment within the federal requirement. Federal regulation requires that all incentive payments combined not exceed this 5% limit; thus the test of the 5% limit will include both the performance-based payment incentives included in this policy and the Quality Measure Performance Incentive payments described in ACOM Policy 306.

Structured Payment File and Post Adjudicated/Post Submitted Files

A. The Division has developed a Structured Payment File to automate the APM Strategies Certification Excel file. The AdSS must submit this file annually. (See AdSS Responsibilites)

B. To link encounters to the Structured Payment File, the AdSS must add an APM Indicator to encounters paid under an APM contract. If the AdSS knows upfront that the encounter is tied to a member/provider under APM contract, the AdSS should include the APM Indicator in the original encounter submission.

If the AdSS does not know upfront that the encounter is tied to a member/provider under APM contract, the AdSS must add the APM Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The AdSS may choose to only use the post adjudication adjustment process to add the APM Indicator to adjudicated encounters, if desired.

All applicable encounters should have the APM Indicator included 270 days following the contract year end.

311 CYE 20 AND FORWARD – TIERED CAPITATION RECONCILIATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2905, AHCCCS Financial Reporting Guide; Section 9010 of the Patient Protection and Affordable Care Act, Section F3, Contractor Chart of Deliverables

This Policy applies to the Division's Administrative Services Subcontractor (AdSS). The purpose of this Policy is to outline the process and AdSS requirements regarding the DDD Health Plan Tiered Prospective Reconciliation. The reconciliation applies to dates of service effective on and after October 1, 2019 and is based upon total medical expenses and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS profit or loss for all risk groups as described below using a tiered approach. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis.

Definitions

A. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) awarded to the AdSS including any administrative adjustments deemed necessary by the Division during the capitation rate setting process multiplied by the actual prospective member months for the contract year being reconciled. For any rates that are not bid by the AdSS, but are set by the Division, the administrative component is equal to the administrative PMPM built into the capitation rates multiplied by the actual prospective member months for the contract year being reconciled.

B. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

C. Non-Capped Newborn Expenses - In accordance with the contract, AdSS must notify the Division of a newborn born to an ALTCS mother within one day of the date of birth. When notification is received timely, the AdSS receives capitation retroactive to the birth date. When notification is received late, the AdSS receives capitation beginning on the date of notification, but expenses must be covered by the AdSS back to the date of birth. Encounters for dates of services from the date of birth to the day before a tardy notification are considered non-capped expenses and are excluded from capitation rate development and reconciliations.

D. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. §36- 2905 for all payments made to AdSS for the contract year.

E. Prospective and Prior Period Coverage Medical Expense - Prospective expenses reported through fully adjudicated encounters and subcapitated/block purchase expense incurred by the AdSS for covered services with dates of service during the contract year (including expenses incurred during the Prior Period Coverage (PPC) time period) being reconciled.

F. Net Capitation – Prospective and PPC capitation, risk adjusted if applicable, plus Delivery Supplemental payments, less the administrative component, the health insurer fee capitation adjustment and the premium tax component.

G. Reinsurance - For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the AdSS as the result of prospective medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

H. Subcapitated/Block Purchase Expense - Expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated /block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

General

A. The tiered prospective reconciliation shall be based on net capitation less prospective and PPC medical expense plus reinsurance payments. The amount due from or due to the AdSS as the result of this reconciliation will be based on aggregated profits and losses across all of the tiered reconciliation groups. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

B. The reconciliation will limit the AdSS profits and losses to the percent of net capitation according to the following schedule:

PROFIT	AdSS SHARE	STATE SHARE	MAX AdSS PROFIT	CUMULATIVE AdSS PROFIT
<= 1%	100%	0%	1%	1%
>1%	0%	100%	0%	1%

LOSS	AdSS SHARE	STATE SHARE	MAX AdSS LOSS	CUMULATIVE AdSS LOSS
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Note: Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.

Division Responsibilities

A. No sooner than six months after the end of the period to be reconciled, the Division shall perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

Profit/Loss to be reconciled = Net Capitation – Total Medical Expenses – Subcapitated/block purchase Expense + Reinsurance payments.

Profit/Loss % = Profit/Loss to be reconciled divided by Net Capitation.

Note: ACOM 311, Attachment A provides an example of the tiered reconciliation calculation.

B. The Division will utilize only total medical expense supported by fully adjudicated encounters and subcapitated expense reported by the AdSS to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

C. The Division will utilize amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self- reported subcapitated/block purchase expense included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

G. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

H. The Division may include adjustments to the reconciliations to account for completion factors.

AdSS Responsibilities

A. The AdSS must submit encounters for prospective and PPC medical expenses and those encounters must reach fully adjudicated status by the required due dates. The Division will only utilize fully adjudicated encounters reported by the AdSS to determine the medical expenses used in the reconciliation.

B. The AdSS must maintain financial statements that separately identify all group transactions, and shall submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide.

C. The AdSS must monitor the estimated program tiered reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide and as specified in *Contract, Contractor Chart of Deliverables*.

D. It is the AdSS responsibility to identify to the Division any encounter data issues, or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

E. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

F. The AdSS must report all subcapitated/block purchase expense in a format requested by the Division.

G. If the AdSS performs recoupments/refunds/recoveries on prospective claims, the related encounters must be adjusted (voided or void/replaced) pursuant to AdSS Operations Manual, Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation.

312 CHILDREN'S REHABILITATIVE SERVICES PROGRAM RECONCILIATION

EFFECTIVE DATE: 10/1/2018

REFERENCES: A.R.S. §36-2905, 9 A.A.C. 22 Article 1, ACOM Policy 325, ACOM Policy 412,

Patient Protection and Affordable Care Act Section 9010, AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

The Children's Rehabilitative Services (CRS) Program Reconciliation is based on adjudicated medical expense and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS's profit or loss for the CRS program as described below. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis.

Definitions

A. Administrative Component – an amount equal to the administrative. Per member Per Month (PMPM) awarded to the AdSS, including any administrative adjustments deemed necessary by the Division during the capitation rate setting process, multiplied by the actual member months for the contract year being reconciled.

B. Access to Professional Services Initiative (APSI) - effective October 1, 2017 and forward, is an initiative where AHCCCS seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Division's rates for professional services provided by qualified physicians and non-physician professional affiliated with designated hospitals who meet the definition outlines in ACOM Policy 325.

C. Health Insurer Fee Capitation Adjustment - an amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

D. Medical Expense - expenses reported through fully adjudicated encounters and subcapitated/block purchase expenses incurred by the AdSS for covered services with dates of service during the contract year. This will exclude APSI expenses.

E. Net Capitation - capitation less the administrative component, the health insurer fee capitation adjustment, APSI capitation, and the premium tax component.

F. Premium Tax Component - is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to the AdSS for the contract year.

G. Prior Period Coverage (PPC) - period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the

effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the AdSS. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the AdSS only on a prospective basis.

H. Reinsurance - for purposes of this reconciliation, the actual reinsurance payments received by the AdSS as the result of medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

I. Subcapitated/Block Purchase Expenses - expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated/block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

J. Reconciliation Population - all CRS members, except State Only Transplant members, subject to this reconciliation.

General

The CRS reconciliation must be based on net capitation less medical expense plus reinsurance payments. The amount due from, or due to, the AdSS as the result of this reconciliation will be based on aggregated profits and losses across the reconciliation population. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to Division cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation. The enhanced portion of a payment for APSI that is subject to a unique reconciliation as outlined in ACOM 325 will also be excluded from this reconciliation.

The reconciliation will limit the AdSS's profits and losses to the percent of net capitation according to the following schedule, per contract year as noted:

Profit	AdSS Share	State Share	Max AdSS	Cumulative AdSS Profit
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Loss	AdSS Share	State Share	Max AdSS	Cumulative AdSS Loss
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.

Division Responsibilities

A. No sooner than six months after the end of the period to be reconciled, the Division will perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

Profit/Loss to be reconciled = Net Capitation − Medical Expense − Subcapitated Expense/Block Purchase Expenses + Reinsurance payments.

Profit/Loss % = Profit/Loss to be reconciled divided by Net Capitation.

B. The Division will use only medical expense supported by fully adjudicated encounters and subcapitated/block purchase expenses reported by the AdSS to determine the expense subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to Division cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

C. The Division will use amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/ block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self-reported subcapitated or block purchase expenses included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

G. The Division may include adjustments to the reconciliations to account for completion factors.

AdSS Responsibilities

A. The AdSS must submit encounters for prospective medical expense and those encounters must reach fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the medical expense used in the reconciliation.

B. The AdSS must maintain financial statements that separately identify all CRS transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor.

C. The AdSS must monitor the estimated CRS program reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor.

D. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data submitted for reconciliations by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

E. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file, reinsurance payments).

F. The AdSS must report all subcapitated/block purchase expenses in a format requested by the Division. Subcapitated and block purchase encounters should have a CN 1 code of 05 and a paid amount of $0 for all non-PCP rate parity encounters. All subcapitated encounters that have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures. This includes all subcapitated amounts greater than $0 for PCP Rate Parity that are subject to Division cost settlement.

G. If the AdSS performs recoupments/refunds/recoveries on the related claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due to the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.

314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019
REFERENCES: Administrative Services Contract

This policy describes the method used to auto-assign members to an AdSS.

A. Upon award of a new contract, the Division will auto-assign members as follows:

1. Prior to the start of the contract (choice period), current members will be given a choice to select from the newly awarded AdSS contractors.

2. If a member does not select an AdSS during the choice period and the member's current AdSS is awarded a contract, the member will be reassigned to the same AdSS.

3. If a member does not select an AdSS during the choice period and the member's current AdSS is NOT awarded a contract, the member will be auto-reassigned to one of the newly contracted AdSS.

4. Auto-assignment to a newly contracted AdSS will continue until the number of members assigned to the newly contracted AdSS reaches 50% of the number of members assigned to the AdSS that continued to contract.

5. If all AdSS are new, the members will be given a choice to select an AdSS prior to the start of the contract.

B. Ongoing, the Division will auto assign to the available AdSS in a revolving sequence. The Division may change the auto assignment process at any time during the term of the contract in response to AdSS-specific issues (e.g., imposition of an enrollment cap), when in the best interest of the ALTCS Program and/or the state, or to recognize and reward AdSS performance across a variety of factors of importance to the Division.

317 CHANGE IN ORGANIZATIONAL STRUCTURE

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 101-106; ACOM Policy 438, 103; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Change in Contractor Organizational Structure: Notification; Change in Contractor Oorganizational Structure: Transition Plan Final Documents; Change in Contractor Organizational Structure: Transition Plan Initial Documents; Completed Change in Contractor Organizational Structure: Documents required after AHCCCS Approval

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes the procedure for approval of AdSS changes in Organizational Structure as defined below, including changes in a Management Service Agreement (MSA) subcontractor.

Definitions

A. Acquisition – an acquiring, by one company, of all of a target company's assets, capital, or stock.

B. Administrative Services Subcontract - agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:

1. Claims processing, including pharmacy claims
2. Credentialing, including those requirements for only primary source verification
3. Management Service Agreements (MSAs)
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSSs.

C. Articles of Incorporation - basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

D. Change In Organizational Structure - any of the following:

1. Acquisition
2. Change in Articles of Incorporation
3. Change in ownership
4. Change of MSA subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet Division contractual requirements)

5. Joint venture

6. Merger

7. Reorganization

8. State agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature

9. Other applicable changes that may cause a change in any of the following:

   a. Employer Identification Number/Tax Identification Number (EIN/TIN)

   b. Critical member information, including the website, member or provider handbook and member ID card

   c. Legal entity name.

E. Change in Ownership - any change in the possession of equity in the capital, stock, profits, or voting rights, with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non- stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

F. Joint Venture - business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants' other business.

G. Management Service Agreement (MSA) - type of subcontract with an entity in which the owner of an AdSS delegates all or substantially all management and administrative services necessary for the operation of the AdSS.

H. Merger - Two companies join together to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

I. Performance Bond - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

J. Reorganization - An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work

with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.

Change in AdSS's Organizational Structure

A change in AdSS organizational structure requires notification and prior approval of the Division. When submitting for prior approval, the Division will review documentation to ensure the following:

A. Uninterrupted services and ongoing adequate access to care and choice for members

B. The new entity's ability to maintain and support the contract requirements including the commitments in the proposal submitted to the Division during the procurement process

C. Major functions of the AdSS's organization, as well as Division-funded services, are not adversely affected

D. The integrity of a fair, competitive, procurement process for AdSS contracts.

The Division reserves the right to obtain stakeholder input on the proposed ownership change through a public notice and feedback process, and to temporarily suspend an AdSS's new-member enrollment pending the Division's review and final determination regarding an AdSS's change in organizational structure. The AdSS must submit a written notification to the Division of any proposed merger, acquisition, reorganization, or change in ownership, 180 days before the effective date. This notification must include:

A. A detailed description of the type of change or new corporate structure and the purpose thereof

B. A detailed transition plan as outlined below.

Transition Plan

The AdSS must submit the transition plan 180 days before the effective date. Items for which information is not yet available for submission, or is still considered draft, must be noted and must be submitted or resubmitted no later than 90 days before the effective date.

All transition plan documents must be submitted electronically to the Division via the secured File Transfer Protocol (FTP) server.

A. The AdSS must submit the following as part of the transition plan, as applicable:

1. A letter of explanation that includes the following information:

a. The type of entity if a new entity will be formed and/or any changes to existing entity

b. Any material change to operations as specified in Policy 439 of this Manual and contract

2. Documents including the following:

   a. The formal name and any proposed logo used by the resulting organization

   b. The organizational chart of the new resulting organization or proposed changes to the existing organizational chart if a new entity is not being formed

   c. Current audited financial statements of current AdSS and merging entity

   d. Pro forma financial statements of entity resulting from the change in organizational structure that include, at a minimum: a balance sheet, statement of revenues and expenses, and statement of cash flows for the subsequent three years, and enrollment projections and footnotes detailing assumptions. The format can be the same as the audit format; however the Division lines of business should be detailed separately just as is required in the annual audit report.

3. A description of the following:

   a. An assessment of any potential interruption of services to members, and steps the AdSS is taking to ensure there are no interruptions

   b. Any changes to the management and staffing of the organization currently overseeing services provided under the contract

   c. Any changes to existing Administrative Services Subcontracts

   d. Any changes to the administration of critical components of the organizations, including but not limited to information systems, prior authorization, claims processing or grievances

   e. The AdSS's plan for communicating the change to members, including a draft notification to be distributed to affected members and providers

   f. The AdSS's plan for changes to critical member information, including the website, member and provider handbook and member ID card

   g. Any anticipated changes to the network.

B. Upon Division approval of the transition plan, the following documents must be submitted within 120 days of the change:

1. The Articles of Incorporation, if applicable, including copies of all affiliation agreements

   An affiliate is an entity that directly or indirectly controls, is controlled by, or is under common control with another entity; also, a party with which

the entity may deal if one party has the ability to exercise significant influence over the other's operating and financial policies. The affiliation agreement (also referred to as a member agreement) defines and governs the affiliate relationship.

2. Any proposed change to the Employer Identification Number/Tax Identification Number (EIN/TIN)

3. Any additional information requested by the Division.

Additional Submission Requirements

The AdSS must submit the following to the Division no later than 45 days before the effective date of the change in organizational structure and commencement of operations under the new structure:

A. Automatic Clearing House (ACH) Vendor Authorization Form

The ACH form is to be submitted as directed on the form in order for the AdSS to begin receiving reimbursement.

B. Information regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime in accordance with the 42 CFR 101 through 106, the Corporate Compliance Contractual Provisions, and Division Policy Manuals

The information is to be submitted via secured FTP server to the Division.

For a change of MSA Subcontractor, the AdSS must also follow the process for the review and approval of the new subcontract as outlined in Division Operations Manual Policy 438.

The Division reserves the right to request additional items deemed necessary to complete the evaluation.

Divison Disposition of Request

The Division will review and respond to the AdSS within 30 days of the Notification and submission of the Transition Plan. Incomplete submissions may require additional information before approval. Upon completion of the review, the Division may:

A. Approve the proposal without conditions.

B. Approve the proposal with conditions that may include, but are not limited to:

1. Allowing an open enrollment for plan membership

2. More rigorous oversight for a specified period of time

3. A cap on enrollment.

C. Deny the proposal.

If the Division denies the proposal, and if the AdSS moves forward, the Division may terminate some or all of the Geographic Service Areas that are part of the contract.

320 HEALTH INSURER FEE (Health Insurance Provider Fee)

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2905, Section 9010 of the Patient Protection and Affordable Care Act; IRS Form 8963; ACOM Policy 320 Attachment A and Attachment B; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Health Insurance Providers Fee: Federal and State Income Tax Filings; Health Insurance Providers Fee: Liability Reporting Template; Health Insurance Providers Fee: Report of Health Insurance Provider Information (IRS Form 8963)

This policy applies to Division's Administrative Services Subcontractors (AdSS). AHCCCS provides funding to the Division for the Health Insurance Provider Fee (HIPF) and associated taxes. The purpose of this policy is to define what the AdSS submits to AHCCCS and the process by which the Division reimburses the AdSS for the HIPF.

Definitions

A. Affordable Care Act (ACA) - Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (ACA).

B. Fee Year - The calendar year in which the fee must be paid.

C. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 for all payments made to contractors for the contract year.

HIPF Requirements and Exclusions

Section 9010 of the ACA requires that the AdSS, if applicable, pay an HIPF annually, beginning in calendar year 2014, based on its respective market share of premium revenues from the preceding calendar year. Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance. Certain entities will be excluded. Excluded entities include, but are not limited to:

A. Government entities, including independent nonprofit county-organized system entities that contract with state Medicaid agencies

B. Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations, including Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), and dual eligible plans.

Additionally, certain entities can exclude 50% of their net premium for the HIPF calculation because of their status as a public charity, social welfare organization, high-risk health insurance pool, or Consumer Operated and Oriented Plan (CO-OP).

Every health insurer must report its national net premiums written to the IRS annually by

April 15 of the fee year on IRS *Form 8963, Report of Health Insurance Provider Information*. The health insurer is responsible for allocating its national net premiums written to the entities recorded on its *Form 8963*. The allocation for each fee year is based on the prior

calendar year's revenue. The IRS will then send each health insurer a notice of preliminary fee calculation each fee year. The regulations provide that the IRS will send each health insurer its final fee calculation for a fee year no later than August 31 of that fee year, and that the health insurer must pay the fee to the IRS by electronic funds transfer by September 30.

AHCCCS Responsibilities

A. Subject to receipt and review of documentation from the AdSS as described below, AHCCCS will make a retroactive capitation rate adjustment to the Division consistent with the methodology approved by the Centers for Medicare and Medicaid Services (CMS).

   For CMS-approved methodology to approximate the cost associated with the HIPF Premium tax, see AHCCCS Contractor Operations Manual (ACOM) *Policy 320 Attachment A, CMS Approved Retroactive Capitation Rate Adjustment Methodology – One Month Method of Payment of Health Insurer Fee (HIPF)*.

B. For Fee Year 20 and forward, the retroactive capitation rate adjustment for the AdSS in "A" above will include the provision to approximate the federal income tax liability and Arizona state income tax liability incurred related to the HIPF, if applicable.

AdSS Responsibilities

A. The AdSS must submit to the AHCCCS Division of Health Care Management (DHCM) Finance Manager with a copy to the Division's Business Administrator, a copy of its entity's IRS *Form 8963, Report of Health Insurance Provider Information* filed with the IRS to report net premium along with its final fee estimate by September 30 of each fee year.

B. The AdSS must complete ACOM *Policy 320 Attachment B, Health Insurer Fee Liability Reporting Template* and submit both an executed copy and an electronic copy in an Excel format to the DHCM Finance Manager and the Division's Business Administrator by September 30 of each fee year, Since the template includes all lines of business, an AdSS with multiple lines of business only needs to make one submission. The AdSS must include Title XIX only. The AHCCCS fee liability must be allocated to line of business based on the allocation of revenue reported in *Attachment B*. AHCCCS will verify the reasonableness of the data. In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

C. If no fee is due, the AdSS must submit to the DHCM Finance Manager and the

   Division's Business Administrator a written statement indicating no fee is due and the

   reason for the exemption.

D. The AdSS must submit to the DHCM Finance Manager and the Division's Business Administrator a copy of its entity's federal and Arizona state income tax filings by

April 30 of the year following the fee year. The AdSS must notify the DHCM Finance Manager and the Division's Business Administrator of the federal and Arizona state income tax rates that apply to the AdSS.

E. If the AdSS requested a tax filing extension, the AdSS must submit its anticipated federal and Arizona state income tax rates that apply to the AdSS to the DHCM Finance Manager and the Division's Business Administrator by April 30 of the year following the fee year. Within 30 days after submitting tax filing, the AdSS must submit copies of the federal and Arizona state income tax filings.

F. AHCCCS may adjust a capitation rate that was previously adjusted for tax liability purposes if the resulting tax liability is materially different from the anticipated tax rates reported.

G. The AdSS deliverables due to AHCCCS, including IRS Form 8963, Attachment B, and Federal and State Income Tax filings will be waived, should the Federal Government place a suspension on the HIPF, for the fee year in which the HIPF would have been due. See Section F3, Contractor Chart of Deliverables.

321 PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to define parameters for the Payment Reform-E-Prescribing Initiative.

Definitions

A. Electronic Prescription or E-Prescription - Electronic Prescriptions or E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.

B. Origin Code **-** The field located in the National Council for Prescription Drug Programs (NCPDP) standardized code set known as the Prescription Origin Code and also referred to as the NCPDP Prescription Origin Code.

General

E-Prescribing is a recognized and proven effective tool to improve members' health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, patient adherence, and increased prescription accuracy.

The following parameters must apply for the Payment Reform - E-Prescribing Initiative:

A. Only those prescriptions that meet the definition of an E-Prescription (see definition above) must be included for the purpose of the initiative. The initiative must not include other electronic methods of transmitting prescriptions, e.g., computer-generated paper prescriptions or facsimiles or telephone-generated prescriptions. The initiative also must not include E-Prescriptions converted to computer-generated facsimile when the E-Prescription is sent via an intermediary that is unable to complete the transaction.

B. Refills retain the origin of the prescription. Each time a prescription that meets the definition of an E-Prescription is refilled, it counts as an E-Prescription. Consequently, refills must not be counted as electronic originations for this initiative, as they overstate the number of prescriptions generated in this manner.

C. Controlled substances can be E**-**Prescribed and therefore may be counted as an E-Prescription if the electronic origination meets the definition of an E-Prescription.

D. Prescriptions generated by nurse practitioners and physician assistants may be counted as electronic originations if they meet the definition of an E-Prescription.

The Division may sanction the AdSS for failure to meet the requirements in the AdSS Responsibilities section of this policy.

AdSS Responsibilities

For CYE 16: The AdSS must increase the percent of prescriptions originating through E-Prescribing by 20% of the difference between the CYE 15 baseline percentage of original prescriptions generated as E-Prescriptions by line of business and the goal percentage of original prescriptions generated as E-Prescriptions as defined below, using the CYE 16 peak quarter to determine compliance with the E-Prescribing Initiative.

Goal (Percentage of Original Prescriptions Generated as E-Prescriptions)

DDD, including AdSS: 65%

The required increase in the percent of prescriptions originating through E-Prescribing will be calculated as follows:

- G = E-Prescribing percentage Goal
- B = CYE 15 Baseline E-Prescribing percentage
- R = Required E-Prescribing percentage increase from CYE 15 Baseline E-Prescribing percentage per AdSS
- T = Target E-Prescribing percentage per AdSS
- P = CYE 16 Peak Quarter E-Prescribing percentage

Calculation	Example
(G − B) * 20% = R	(60% - 45%) * 20% = 3%
B + R = T	45% + 3% = 48%
P >= T	49% > 48%

Prescription origination data must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.

The Prescription Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.

325 ACCESS TO PROFESSIONAL SERVICES INITIATIVE AND RECONCILLIATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 48-5501 et seq., Division Operations Manual Policy 412

Purpose: To establish guidelines for Administrative Services Subcontractors (AdSS) regarding the Access to Professional Services Initiative (APSI) and related reconciliation.

Policy: The Division of Developmental Disabilities (Division) seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to members and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS rates for professional services provided by qualified practitioners affiliated with designated hospitals.

Due to uncertainty regarding actual use of qualified practitioners, and because the state share of the capitation paid to the AdSS will be funded using Inter-Governmental Transfer funds for this specific purpose, the Division intends to eliminate the financial risk to its AdSS. The Division will isolate the APSI revenue and expenses, and reconcile AdSS prospective and Prior Period Coverage (PPC) profits and losses to 0%. A risk pool will be used to capture unexpended funds.

Definitions

APSI Expense: The PPC and Prospective Expenses incurred by the AdSS for the 40% rate increase to providers. APSI Expenses excludes Subcapitated/Block Purchase Expenses.

APSI Revenue: The amount of additional PPC and Prospective capitation provided for the 40% rate increase to providers.

Designated Hospitals: For purposes of this Policy, designated hospitals include:

- A hospital facility with an Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching program and which is operated pursuant to the authority in A.R.S. Title 48, Chapter 31 (A.R.S. § 48-5501 et seq.); or
- A hospital facility with:
    - An ACGME-accredited teaching program with a state university, and
    - AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2019; or
    - A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than 100 licensed pediatric beds, excluding nursery beds.

Qualified Practitioner: For purposes of this policy, qualified practitioners are providers who bill for services under one of the Group National Provider Identifier numbers that are affiliated with one of the Designated Hospitals identified in Section A.1. of this policy, and includes the following practitioners:

- Physicians, including doctors of medicine and doctors of osteopathic medicine
- Certified Registered Nurse Anesthetists
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dentists
- Optometrists

A. Designated Hospitals

1. Designated Hospitals participating in APSI effective October 1, 2019, include the following:
    a. Banner University Medical Center Phoenix
    b. Banner University Medical Center Tucson
    c. Banner University Medical Center South
    d. Cardon Children's Medical Center at Banner Desert Medical Center
    e. Maricopa Medical Center
    f. Phoenix Children's Hospital
    g. St. Joseph's Hospital and Medical Center
    h. Tucson Medical Center

B. Reconciliation

1. The reconciliation must relate solely to the APSI portion of encounters for fully adjudicated prospective and PPC medical expenses, excluding services provided under subcapitated/block purchase arrangements, for Qualified Practitioners. The amount due from or due to the AdSS as a result of this reconciliation will be based on aggregated profits and losses from APSI

Revenue and Expenses across both prospective and PPC risk groups.

2. The reconciliation will limit the AdSS's profits and losses from APSI Revenue and APSI Expenses to 0%. Any losses in excess of 0% will be reimbursed to the AdSS and, likewise, profits in excess of 0% will be recouped.

C. Administrative Services Subcontractors' Responsibilities

1. Effective with dates of service on and after October 1, 2019, the AdSS will provide a 40% increase to the otherwise contracted rates to Qualified Practitioners for all claims for which the Division is the primary payer.

2. The AdSS must submit encounters for APSI medical expenses, and those encounters must reach fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the APSI medical expenses used in the reconciliation.

3. The AdSS must maintain financial records that separately identify all APSI-related prospective and PPC transactions, and submit such information through a footnote in the financial statements as required by Contract and as specified in the AHCCCS Financial Reporting Guide.

4. The AdSS must monitor the estimated APSI reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide.

5. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

6. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g., encounter detail file).

7. If the AdSS performs recoupments/refunds/recoveries on any APSI claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued APSI reconciliation results for the impact of the revised encounters and recoup any amounts due the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.

D. Division Responsibilities

1. No less than six months after the Contract Year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows: Profit/Loss to be reconciled = APSI Capitation.

2. The Division will use only expenses supported by fully adjudicated encounters reported by the AdSS to determine the expenses subject to reconciliation.

3. The Division will compare fully adjudicated encounters to AdSS financial statements and other AdSS submitted files for reasonableness.

4. The Division will provide to the AdSS the data used for the initial APSI reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

5. A final APSI reconciliation will be performed no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide to the AdSS the data used for the final reconciliation and provide a set time period for review and comment by the AdSS.

6. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

7. Any amount due to or due from the AdSS as a result of the final APSI reconciliation, that was not distributed or recouped as part of the initial reconciliation, will be paid or recouped through a future monthly capitation payment.

8. The Division may include adjustments to the initial APSI reconciliation to account for completion factors.

9. The Division will create and use an APSI risk pool to capture recouped funds. The monies included in the risk pool will be used to reimburse AdSS with losses in excess of 0%.

401 CHANGE OF DDD HEALTH PLAN AND ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 401- Attachment A, AHCCCS Acute Care Change of Contractor Form

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes requirements and timeframes for how, when and by whom AdSS change requests will be processed for members eligible for the Division outside of the AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This policy describes the rights, obligations, and responsibilities of the following parties when such changes are made:

- The Member
- The Relinquishing AdSS
- The Receiving AdSS
- The Division of Developmental Disabilities (DDD or the Division).

Definitions

A. Annual Enrollment Choice (AEC) - The opportunity for a member to change the DDD Health Plan and AdSS every twelve months.

B. Auto Assignment - The process by which members who do not exercise their right to choose an AdSS and members who are not assigned an AdSS based on family continuity rules are assigned to an AdSS through an auto assignment algorithm. The algorithm is a mathematical formula used to assign members to the various AdSSs in a manner that is predictable and consistent with Division goals.

C. Business Day -. A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

D. Freedom of Choice - The opportunity given to each member who does not specify an AdSS preference at the time of enrollment to choose between the AdSSs available.

E. Receiving AdSS - The AdSS with which the member will become enrolled as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

F. Relinquishing AdSS - The AdSS in which the member will be leaving as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

Policy

A. Criteria for Change of AdSS Outside of Initial Enrollment or AEC Period

AdSS change requests outside of the initial enrollment period or the member's AEC period will be granted for members if certain conditions are met. These conditions include:

1. Administrative Actions That May Merit an AdSS Change:

    a. A member was entitled to Freedom of Choice but was not sent a choice letter.

    b. A member was entitled to participate in an AEC but:

        i. Was not sent an choice letter, or

        ii. Was sent a choice letter but was unable to participate in the AEC due to circumstances beyond the member's control.

    c. Family members were inadvertently enrolled with a different AdSSs. A member who is enrolled with an AdSS through the Auto Assignment process may inadvertently be enrolled with a different AdSS than other family members. Upon receipt of notification by the Division, the member who was inadvertently enrolled will be disenrolled from the AdSS of assignment and enrolled with the AdSS where the other family members are enrolled. Other family members will not be permitted to change to the AdSS to which the new member was auto-assigned. This process must not apply if a member was afforded an enrollment choice during their AEC period.

    d. A member loses eligibility and regains eligibility within 90 days. The member shall be reenrolled with the AdSS that the member was enrolled with prior to the loss of eligibility. If this does not occur, the Division, upon notification, will enroll the member with the previous AdSS.

    e. A Title XIX eligible member who is entitled to Freedom of Choice but becomes eligible and is auto assigned prior to having the full choice period of 90 days will be given an opportunity to request an AdSS change following Auto Assignment. The member will be given 90 days from the date of the choice letter to request an AdSS change. A member who does not make a selection within 90 days will remain with the auto assigned AdSS.

2. Medical Continuity of Care

    In unique situations, AdSS changes may be approved on a case-by-case basis if necessary, to ensure the member access to medical/health care.

    A plan change for medical continuity is not an automatic process. The member's Primary Care Provider (PCP), or other medical provider, must provide documentation to both the Receiving and Relinquishing AdSSs that supports the need for an AdSS change. The AdSSs must be reasonable in

the request for documentation. However, the burden of proof that an AdSS change is necessary rests with the member's medical provider. The AdSS change must be approved by both AdSS's Medical Directors.

A pregnant member who is enrolled with an AdSS Auto Assignment or Freedom of Choice and is currently receiving or has previously received prenatal care from a provider who is affiliated with another AdSS, may be granted a medical continuity AdSS change if agreed to by the Medical Directors of both AdSSs. The member must be transitions within the requirements and protocols in AdSS Operation Manual Policy 402 and in Division Medical Policy Manual chapter 500.

When the Medical Directors of both the receiving and relinquishing AdSS have discussed the request and have not been able to come to an agreement, the relinquishing AdSS must submit the request to the Division's Chief Medical Officer (CMO) or designee. Within 14 calendar days from the date of the original request, the Relinquishing AdSS must submit Attachment A and the supporting documentation to the Division for review.

The results of the review will be shared with both Medical Directors. The relinquishing AdSS will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing AdSS will send the member in writing. .The letter will also advise the member of the Division Grievance and Appeal System policy and include timeframes for filing a grievance.

Upon approval of a change in AdSS for medical continuity, the member must be transitioned within the requirements and protocols in AdSS Operations Manual Policy 402 and the Division Medical Policy Manual Chapter 520.

B. AdSS Responsibilities When an AdSS Change is Not Warranted

The current AdSS has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care or delivery issues that may have caused an AdSS change request to be initiated. These issues include, but are not limited to:

1. Quality of care delivery
2. Case management responsiveness
3. Transportation convenience and service availability
4. Institutional care issues
5. Physician or provider preference
6. Physician or provider recommendation
7. Physician or provider office hours

8. Timing of appointments and services

9. Office waiting time

10. Network limitations and restrictions.

When quality of care and delivery of care and service issues raised by the member are identified, the AdSS shall refer the issue for review by the Division's Quality Management Department, who will follow the Division's established Quality Management process for timely resolution.

Additionally, the AdSS must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

The delivery of covered services remains the responsibility of the current AdSS if an AdSS change for medical continuity of prenatal or other medical care is not approved.

The current AdSS must notify the member, in writing, that an AdSS change is not warranted. If the AdSS change request was the result of a member concern, as defined in this Policy, the letter must include the AdSS's resolution of this concern. The letter must also advise the member of the Division and AdSS Grievance and Appeal System policy and include timeframes for filing a grievance.

AdSSs may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

C. Relinquishing AdSS, Receiving AdSS And Division Responsibilities When an AdSS Change is Warranted

1. Relinquishing AdSS Responsibilities

If a member contacts the current AdSS, verbally or in writing, and states that the reason for the plan change request is due to situations defined in this Policy, the relinquishing AdSS must advise the member to telephone the Division Customer Service at 1-844-770-9500 and follow the prompts for health plan changes and questions, in order for the Division to process the change.

If the member contacts the relinquishing AdSS, verbally or in writing, to request a plan change for medical continuity of care as defined in this policy, the following steps must be taken:

a. The relinquishing AdSS will contact the receiving AdSS to discuss the request. If a plan change is indicated for medical continuity of care, ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form must be completed. All members impacted by the

change request must be indicated on the form. The form must be signed by the Medical Directors of both AdSSs. The signed form must be submitted to the Division Chief Medical Officer,

b. To facilitate continuity of prenatal care for the member, the AdSS must sign off and submit the ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form to the Division Chief Medical Officer within two business days of the member's AdSS change request. The timeframe for other continuity of care changes is as expeditiously as the member's health care condition requires, or no later than 10 business days, and

c. The Division Chief Medical Officer will review the AdSS change documentation and process accordingly.

2. Receiving AdSS Responsibilities

The member must be transitioned within the requirements and protocols in AdSS Manual Policy 402 and in the Division Medical Policy Manual Chapter 500.

3. Division Responsibilities

The Division must process change of AdSS requests that are listed in Section A (1) and must send notification of the change via the daily recipient roster to the relinquishing and receiving AdSSs. It is the AdSS's responsibility to identify members from the daily recipient roster who are leaving the AdSS.

If the Division denies a change of AdSS request, the Division will send the member a denial letter. The member will be given 60 days to file a grievance.

If the Division receives a letter or verbal request from a member requesting an AdSS change, for reasons defined in this Policy, that also references other concerns (e.g., transportation, accessibility or availability of services), that information will be sent to the current AdSS who must follow the Policy requirements as outlined above.

402 MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE AND ELIGIBILITY CHANGES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-101

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines, criteria, and timeframes for how members are to be transitioned between AdSSs and how AdSSs are notified for Annual Enrollment Choice (AEC) and eligibility changes. This policy explains the rights, obligations, and responsibilities of the member's current (relinquishing) AdSS and the requested (receiving) AdSS. The AdSS and the Division work together to ensure the smooth transition of members as they change from one AdSS to another. Maintenance of continuity and the quality of care are the overriding considerations for member transitions (the process during which members change from one AdSS to another).

This policy does not include requirements for the following member transitions:

A. Transitions due to AdSS Award, AdSS Termination, or material change to the AdSS's network

B. Transitions due to member request for AdSS change outside of AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period

C. Member transition between ALTCS/Elderly and Physically Disabled (EPD) and Division contractors. Members may be transitioned between an ALTCS/EPD contractor and Division. Transfers between an ALTCS/EPD contractor and the Division are the result of a change in Division eligibility, as determined by the Division.

Definitions

A. Annual Enrollment Choice (AEC) - the opportunity for a member to change the model and AdSS during the Division's open enrollment period.

B. Enrollment Transition Information (ETI) - member-specific information the relinquishing AdSS must complete and transmit to the receiving AdSS for those members requiring coordination of services as a result of transitioning to another contractor (see Division Medical Manual Chapter 500).

C. Health Care Professional - physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

D. Geographic Service Area (GSA) - an area designated by the Division within which a contractor of record provides, directly or through subcontract, covered health care

service to a member enrolled with that contractor of record, as defined in A.A.C. R9-22-101.

E. Potential Plan Listing (PPL) - a file which provides the Division with the basic demographic information of all members who may be joining or leaving.

F. Receiving AdSS - contractor with which the member will become enrolled as a result of AEC, open enrollment, a contractor change or a change in eligibility.

G. Relinquishing AdSS - contractor from which the member will be leaving as a result of AEC, open enrollment, a contractor change or a change in eligibility.

Policy

A. Transitions

1. AEC

a. Members residing in a county with choice of model and AdSS may change enrollment once a year.

i. The Division provides notice to members regarding annual enrollment 60 days before the member's AEC date.

ii. The member may choose a new model and AdSS by contacting the Division to complete the enrollment process.

iii. Members who notify the Division of their choice of model and AdSS prior to AEC will transition to the requested model or AdSS (receiving AdSS) on the first day of the new enrollment period. Members will receive services from their requested AdSS (receiving AdSS) on the first day of the new enrollment period.

b. If the member does not participate in the AEC, no change of model and AdSS will be made.

c. Members must maintain eligibility as a condition of enrollment in the Division and ALTCS.

i. If a member loses eligibility after making an AEC and regains eligibility within 90 days, the member's AEC will be honored.

ii. If the member regains eligibility after 90 days, members who make a choice of model and AdSS will be enrolled with the model and AdSS of choice, if a choice is not made, the member will be auto-assigned to an available AdSS.

iii. The Division sends a choice notice to the member, after the member is auto-assigned, allowing the member 90 days to choose an available AdSS.

2. Eligibility Changes

Member transitions due to eligibility changes include, but are not limited to, Acute Care to the Division.

Members who become eligible for the Division will be transitioned as outlined in this policy, and Division Medical Manual Chapter 500.

B. Division Enrollment Notification to AdSS

1. Final notification data containing the member's choice of AdSS is provided via the 834 file.

2. Enrollment notification data is provided daily and monthly as follows:

i. Daily Enrollment Notification (834 File) is completed by the Division between 8:00 p.m. and 11:59 p.m. each night for that day's activity.

ii. Monthly Enrollment Notification (834 File) occurs three days before the first of the next month for each Division AdSS.

C. AdSS Transition Policy

The AdSS must develop and implement policies and procedures for the acceptance and transfer of members in accordance with contract and Division policy.

D. Transition Coordinator

The AdSS must identify a representative to serve as Transition Coordinator. The Transition Coordinator must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all transition issues, responsibilities, and activities.

The role of the Transition Coordinator includes:

1. Ensuring the transition activities are accomplished in accordance with Division and AdSS policies and procedures

2. Acting as an advocate for members leaving and joining the AdSS

3. Facilitating communication between AdSSs and the Division

4. Assisting Primary Care Providers (PCPs), internal AdSS departments, and other contracted providers with the coordination of care for transitioning members

5. Ensuring continuity of care is maintained during transitions

6. Participating in Division transition meetings.

E. Relinquishing AdSS Responsibilities

The relinquishing AdSS must complete and transmit ETI to the appropriate parties no later than 10 business days of receipt of the Division notification described above for each member who has special circumstances. The AdSS must comply with the notification requirements specified in Division policy for all member transitions.

Special circumstances include, but are not limited to, medical conditions or circumstances such as pregnancy, major organ or tissue transplantation services which are in process, Serious Mental Illness, chronic illness which has placed the member in a high-risk category, and other conditions, circumstances, and all members eligible for the Division.

The relinquishing AdSS must:

1. Coordinate care for members with special health care needs with the receiving AdSS to ensure that services are not interrupted.

2. Be responsible for timely notification to the receiving AdSS of pertinent information related to any special needs of transitioning members.

3. Notify the receiving AdSS.

   Relinquishing AdSSs, who fail to notify receiving AdSSs about members that meet the Division transition notification requirements specified in Division Medical Policy Manual Chapter 500, will be responsible for the cost of medically necessary services received by the member for the first 30 days. The scope and responsibility for such cases will be reviewed and determined by the Division.

   If the Division determines that the relinquishing AdSS is responsible for payment of services following the transition date, the Division will require the receiving AdSS to provide the Division with information about all costs incurred by the member during the period determined by the Division. Failure to timely provide the requested information to the Division will void the receiving AdSS's claim to reimbursement in that case.

4. Notify the hospital before transitioning a member who is hospitalized on the date of transition and comply with the requirements of the Division Medical Policy Manual Chapter 500.

5. Be responsible for ensuring that a transitioning member's medical records are copied and transmitted when requested by the member's new PCP or designated office staff.

   In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing AdSS is responsible for the cost of copying and postage.

   The member is never required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving AdSS.

6. Ensure coverage and provision of medically necessary services to their

assigned members through the date of transition.

An AdSS must never cancel, postpone, or deny a service based on the fact that a member will be transitioning to another AdSS.

7. Be responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the relinquishing AdSS's duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

8. Remain responsible for adjudicating all pending member grievances and appeals that are filed before the member's transition.

F. Receiving AdSS Responsibilities

Receiving AdSSs which fail to timely act upon ETI or fail to timely coordinate or provide the necessary covered services to transitioning members after being properly notified will be subject to sanctions as outlined in contract and AdSS Operations Manual Policy 408.

The receiving AdSS must perform the following:

1. Coordinate care for members with special health care needs with the relinquishing AdSS so that services are not interrupted, and provide the new member with AdSS and service information, emergency numbers and instructions about how to obtain services.

2. Do not delay the timely process of a transition because of missing or incomplete information.

   If notification of a transition is received before a relinquishing AdSS's ETI, the receiving AdSS must begin care coordination efforts immediately upon notification.

3. Extend previously approved prior authorizations for a minimum period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's representative.

4. Provide at a minimum a 90-day transition period, for children who have an established relationship with a PCP that does not participate in the AdSS's provider network, during which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the AdSS, and/or Support Coordinator finds an alternative PCP within the AdSS's provider network.

5. Allow members who are in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

6. Provide new members with member information within timeframes outlined in AdSS Operations Manual Policy 404.

7. Ensure that transitioning members are assigned to a PCP and can obtain routine, urgent, and emergent medical care in accordance with Division standards.

8. Be responsible for the payment of obstetrical and delivery services when a pregnant woman who is considered high-risk, is in her third trimester, or is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery. If the member's current physician and/or facility selected as her delivery site are not within the receiving AdSS's provider network, the receiving AdSS must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving AdSS's contracted network.

404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

REVISION DATE: 1/10/2024, 10/26/2022

REVIEW DATE: 8/4/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10; 42 CFR 438.10(c)(4)(ii); 42 CFR 438.310(d)(3); 42 CFR 438.10(d)(4); 42 CFR 438.10(f)(1); 42 CFR 457.1207; A.R.S. § 46-297; A.A.C. R9-22-504; ACOM 404; ACOM 404, Attachment A, ACOM 404, Attachment B, and ACOM 404, Attachment C

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) as it sets forth requirements regarding Member information and the approval process for Member Information Materials developed or used by the AdSS. This policy pertains to oral and written communication disseminated to AdSS's enrolled Members and to the content of an AdSS's website.

DEFINITIONS

1. "Dual Eligible Special Needs Plan" or "D-SNP" means a type of health benefits plan offered by a Centers for Medicare and

Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII) program covered health benefits and full Medicaid (Title XIX) program covered health benefits.

2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as

specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "File and Use" means a process whereby the AdSS submits qualifying Member Information Materials to the Division prior to use and can proceed with distributing the materials without any expressed approval from the Division.
4. "Human Immunodeficiency Virus" or "HIV" means a Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease. HIV is also commonly transmitted through direct contact with certain bodily fluids (e.g., sharing syringes for intravenous substance use) such as blood, semen, rectal fluids and vaginal fluids, and breast milk.

5. "Incentive Item" means items that are used to encourage behavior changes in the AdSS's enrolled Members or Health promotion incentives to motivate Members to adopt a healthy lifestyle and/or obtain health care services.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Member Information Materials" means any materials given to the AdSS's membership. This includes, but is not limited to; Member handbooks, Member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.
8. "Prior Authorization" or "PA" means A process by which AHCCCS or the Contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness,

compliance with this Article and any applicable Contract provisions. Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.

9. "Retention Materials" means Member Information Materials sent to Members prior to and during Annual Enrollment Choice (AEC) for the purposes of retaining Members as an enrollee with the AdSS.
10. "Value-Added Services" means services, benefits, or positive incentives that promote healthy lifestyles and improve health outcomes among Members, including items previously defined as Member "Incentive Items."
11. "Vital Materials" means written materials that are critical to obtaining services which include, at a minimum, the following:
    a. Member Handbooks,
    b. Provider Directories,
    c. Consent Forms,
    d. Appeal and Grievance Notices,
    e. Denial and Termination Notices.

POLICY

A. MEMBER INFORMATION MATERIALS

1. The AdSS shall obtain approval from the Division for all Member informational materials (messages) including, but not limited to, print, e-mail, and voice-recorded information messages.
2. The AdSS shall comply with the requirements in this Policy for all Member Information Materials as well as the following related requirements:
    a. Cultural Competency, Language Access Plan and Family/Patient Centered Care (AdSS Operations 405);
    b. Member Handbook and Provider Directory (AdSS Operations 406);
    c. Social Networking activities (AdSS Operations 425);
    d. Member ID Cards (AdSS Operations 433);
    e. Change in Contractor Organizational Structure or change in Contractor name (ACOM 317);
    f. Material Changes (ACOM 439);

g. Notice of Adverse Benefit Determination and Notice of Extension notice (AdSS Operations 414);

h. Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters, when indicated; and

i. Maternal Child Health/EPSDT Member outreach information (AMPM Exhibit 400-3).

3. The AdSS shall attest it is in compliance with Member Information requirements by signing and submitting ACOM 404 Attachment C.

4. The AdSS shall provide all Member Information Materials to Members and potential Members in a manner and format that may be easily understood and is readily accessible by Members and Potential Members.

5. The AdSS shall inform Members that Member Information Materials are available in paper form, without charge and upon

request, and shall provide these materials upon request within five business days.

6. The AdSS shall use state developed Member notices as indicated in Contract and Policy.
7. The AdSS shall make a good faith effort to give written notice to Members who received primary care from, or who are seen on a regular basis by, a provider who is terminated from the network. Written notice shall be provided to the Member:
    a. Within the later 30 calendar days prior to the effective date of the provider termination; or
    b. 15 calendar days after the receipt or issuance of the provider termination notice.
8. The AdSS shall submit draft Member notifications that are components of a material change even if previously submitted as a Member information material.
9. The AdSS shall ensure appropriate population health management for Member Information Materials when telephonic

and mail-based care management are not sufficient or suitable, including but not limited to the following settings:

a. Members who are homeless;

b. Members who are in shelters;

c. The Member's home; or

d. The Member's place of employment or school.

B. LANGUAGE, READABILITY, INTERPRETATION AND TRANSLATION REQUIREMENTS

1. The AdSS shall ensure all Member Information Materials include taglines in the prevalent non-English languages in Arizona and include large print, conspicuously visible font size, explaining the availability of written translation or oral interpretation services with the AdSS's toll free and TTY/TDY telephone numbers for customer service which shall be available during normal business hours.
2. The AdSS shall provide Members the AdSS' toll free and TTY/TDY nurse triage line telephone number, to be available 24hr/7days a week.

3. The AdSS shall make Vital materials available in the prevalent non-English language spoken for each Limited English Proficiency (LEP) population.
4. The AdSS shall not substitute Oral Interpretation services for written Translation of Vital Materials.
5. The AdSS shall ensure translation of Vital Materials is accurate and culturally appropriate.
6. The AdSS shall translate all written materials for Members into Spanish regardless of whether or not the materials are vital.
7. The AdSS shall ensure that all information prepared for distribution is written in an easily understood language and format for readability through the following measures:
    a. Maintain the information at a sixth grade reading level as measured on the Flesch-Kincaid scale.
    b. Use a font size no smaller than 12 point.
    c. Member Information Materials made available in alternative formats and in an appropriate manner that

takes into consideration special needs including but not limited to:

i. Visual limitation,

ii. Other disabilities, or

iii. Limited reading proficiency.

d. Large print materials made available using a conspicuously visible font size.

8. The AdSS shall make oral interpretation services, as well as written translation of documents from English into the Member's preferred language, available to Members at no cost. This applies to American Sign Language and all non-English languages, not just those identified as prevalent.

9. The AdSS shall ensure interpretative services including the use of auxiliary aids such as TTY/TDY are made available.

C. VALUE-ADDED SERVICES

1. The AdSS shall offer Value-Added Services to Members which promote healthy lifestyles and improve health outcomes.

2. The AdSS shall not offer Value-Added Services to Members to influence continued enrollment with the Division.
3. The AdSS shall not offer Value-Added Services such as Incentive Items that are exchangeable for items prohibited.
4. The AdSS shall offer Value-Added Services offered in a culturally sensitive, unbiased, and equitable manner.
5. The AdSS shall not receive compensation for Value-Added Services and shall not report the cost of Value-Added Services as allowable medical or administrative costs.

D. MATERIALS NOT REQUIRING SUBMISSION TO THE DIVISION

1. AdSS shall not submit the following materials for approval:
    a. Customized letters for individual Members.
    b. Information sent by the AdSS to Members enrolled in an AdSS's Medicare Dual Special Needs Plan (D-SNP) that clearly and exclusively relate to their Medicare benefits and services.
    c. Health related brochures developed by a nationally recognized organization included in ACOM Policy 404

Attachment A, do not require submission prior to distribution to Members, unless they reference any of the following, in which case the AdSS shall not distribute them at all, although the AdSS may utilize them to develop their own materials:

i. Services which are not medically necessary;

ii. Services which are not AHCCCS covered benefits; or

iii. Services which do not align with Division policy.

2. The AdSS shall submit a request to add names to ACOM 404 Attachment A of national organizations to be recognized by AHCCCS, upon identifying an organization missing from the list.
3. The AdSS shall refer to ACOM 404 for updates when considering using information from organizations listed in ACOM Policy 404 Attachment A.
4. The AdSS shall review the content of materials developed by the organizations listed in Attachment A to ensure that:

    a. The services are covered under the AHCCCS program.

b. The information is accurate.

c. The information is culturally sensitive.

5. The AdSS shall supplement or replace educational brochures customized for Medicaid Members developed by outside entities to educate Members.

E. MEMBER NEWSLETTER CONTENT AND REQUIREMENTS

1. The AdSS shall develop and distribute, at a minimum, two Member newsletters during each contract year.
2. The AdSS shall submit newsletters in the form of an initial mock-up version of what the Member will be receiving in addition to the individual articles referencing readability levels.
3. The AdSS shall not use the File and Use review process for the Member newsletter.
4. At a minimum, the Member newsletter shall include the following at least annually, except as otherwise indicated:
   a. Educational information on chronic illnesses and ways to self-manage care;

b. Reminders of flu shots and other preventative measures at appropriate times;

c. Medicare Part D issues;

d. Cultural Competency, other than translation services;

e. Contractor specific issues, in each newsletter;

f. Tobacco cessation information;

g. HIV/AIDS testing for pregnant women;

h. Suicide Prevention information;

i. Opioid/Substance Use information;

j. Information on Peer and Family supports;

k. AdSS contact information and 988 Crisis Hotline information in each newsletter;

l. Educational information on how the AdSS is addressing health equity and resources to assist with Social Determinants of Health;

m. Where to find resources for support with health-related social needs, which may include a link to the AdSS's Community Resource Guide;

n. Information on the AdSS's integration efforts to improve overall Member outcomes, as applicable;

o. Information on Non-Title XIX/XXI Services as appropriate; and

p. Other information required by the Division or AHCCCS.

F. WEBSITE CONTENT

1. The AdSS's website shall contain all the information required in ACOM Policy 404- Attachment B.
2. The AdSS shall provide written notice to Members of the availability for the newsletter if newsletters are provided electronically.
3. The AdSS shall submit Attachment B as specified in Contract, annually.
4. The AdSS shall ensure:
   a. All of the information is located on the AdSS's website in a manner that Members can easily find and navigate.
   b. Information is in a format that can be retained and printed by the Member.

c. Websites are specific to the AdSS's Medicaid program and shall not include links or references to private insurance.

5. The AdSS website shall contain links and references to the AdSS's Medicare programs and services that exclusively promote coordination of care for Members enrolled in both Medicaid and Medicare.

6. The AdSS shall refer to ACOM 404 for requirements for the approval process for additional information added to the AdSS's website that is directly related to Members or potential Members.

G. SUBMISSION, REQUIREMENTS AND RESTRICTIONS FOR ALL OTHER MATERIALS

1. The AdSS shall inform all Members of any changes considered to be significant by the Division, 30 calendar days prior to the implementation date of the change including:

   a. Cost Sharing

   b. Prior Authorization

   c. Service Delivery

   d. Covered Services.

2. The AdSS shall make a good faith effort to give written notice to Members within 15 calendar days after receipt or issuance of a provider termination notice to each Member who received their primary care from, or is seen on a regular basis by, the terminated provider.
3. The AdSS shall submit to the Division all other Member Information Materials intended for dissemination to Division Members at least 15 calendar days before they are to be released, for File and Use review, excluding surveys which are not subject to File and Use review.
4. The AdSS shall request an expedited review if a 15-day notice is not possible.
5. The AdSS shall ensure expedited requests are clearly marked as expedited.
6. The AdSS shall ensure expedited requests contain the reason for the shortened time frame.

7. The AdSS shall consider factors and materials which may require additional time to be reviewed include but are not limited to Member Information Materials which are:
    a. A component of new initiatives,
    b. Special projects,
    c. Consisted of bulk submission.
8. The AdSS shall submit the following information to the Division prior to releasing Member Information Materials:
    a. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its Members or Potential Members.
    b. Translations of the material into other languages as required by this policy are not required to be submitted.
    c. A cover letter containing a description of the purpose, the process the AdSS shall use to disseminate the material.
    d. The reading level of the material as measured on the Flesch-Kincaid scale.

9. The AdSS may disseminate the Member information as indicated in their request upon the expiration of the 15-day time period unless the Division notifies the AdSS otherwise.
    a. Member materials submitted outside of standard business hours shall be considered received the following Business Day.
    b. State Holidays that fall on business days are not counted as part of the 15-day review period.
10. The AdSS shall consider factors and materials which may require additional time to be reviewed include Member Information Materials which are:
    a. A component of new initiatives;
    b. Special projects;
    c. Consisted of bulk submission.
11. The AdSS shall submit Member Information Materials to the Division for approval, prior to using them for marketing purposes as specified in ACOM 101.
12. The AdSS shall ensure:

a. All materials shall be labeled with the AdSS's name or logo, this includes Member material that is:
    i. Located on the AdSS's website;
    ii. E-mail messages;
    iii. Voice or text-recorded phone messages delivered to the Member's phone; and
    iv. Other information as requested by AHCCCS.
b. Information contained within the material is:
    i. Accurate;
    ii. Updated regularly; and
    iii. Appropriately based on changes in benefits; Contract, policy, or other relevant updates.
c. Updated Member information is re-submitted for approval, including:
    i. The date the material was previously approved;
    ii. The reason for the update; and
    iii. Clearly identify all content revisions.

d. A log is kept for all Member material distributed each year; the log shall identify:
    i. The date the materials were originally submitted to the Division as described in this policy; and
    ii. Resubmission dates.
e. The log of Member Information Materials is made available to the Division upon request.
f. Member Information Materials:
    i. Do not directly or indirectly refer to the offering of private insurance;
    ii. Do not include inaccurate, misleading, confusing or negative information about AHCCCS, the Division or the AdSS, or any information that might defraud Members;
g. Member Information Materials do not use the word “free” in reference to covered services.

h. Member Information Materials directly relate to the administration of the Medicaid program, or relate to health and welfare of the Member

i. Member Information Materials do not have political implications, and

j. Retention Materials do not refer to competing plans.

405 CULTURAL COMPETENCY, LANGUAGE ACCESS PLAN AND FAMILY MEMBER-CENTERED CARE

REVISION DATE: 04/26/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 457.1230(a), 42 CFR 457-1201(d), 42 CFR 438.3(d)(4), 45 CFR Part 92, 42 CFR 438.206(c)(2); Section F3, ACOM Policy 405, Attachment A

PURPOSE

This policy sets forth the Division of Developmental Disabilities' (Division) requirements for Administrative Services Subcontractors (AdSS) in offering accessible and high quality services in a culturally competent manner when providing family and member-centered care, as applicable.

DEFINITIONS

1. "Cultural Competency" means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables that system, agency, or those professionals to work effectively in cross-cultural situations.

a. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.

b. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

c. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

2. "Family-Centered" means care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate the member directs the involvement of the family to ensure person-centered care.

3. "Interpretation" for the purpose of this policy means the act of verbally conveying the content and spirit of the original message, taking into consideration the cultural context.
4. "Language Assistance Service" means services including, but not limited to:
    a. Oral language assistance, including Interpretation in non-English languages provided in-person or remotely by a Qualified Interpreter for an individual with limited English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with Limited English Proficiency,
    b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages other than English; and
    c. Taglines.
5. "Limited English Proficiency (LEP)" means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be

limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

6. "Linguistic Need" means, for the purposes of this policy, the necessity of providing services in the member's primary or preferred language, including sign language, and the provision of Interpretation and Translation services.
7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
8. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone, a video remote interpreting (VRI) service, or an on-site appearance:
    a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,
    b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized

vocabulary, terminology and phraseology, considering cultural appropriateness; and

c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.

9. "Qualified Translator" means for the purpose of this policy, a translator who:

a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

b. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

c. Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any

necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

10. "Translation" for the purpose of this policy means the conversion of written communication, while taking into consideration the cultural context, content and spirit of the message, while maintaining the original intent.
11. "Vital Materials" means information, provided to the member, which assists the member to receive covered services through the Arizona Long Term Care System (ALTCS) program. These materials include but are not limited to:
    a. Member handbooks,
    b. Notices of Adverse Benefit Determinations,
    c. Notices of Appeal Resolution,
    d. Consent forms,
    e. Member notices,
    f. Communications requiring a response from the member,

g. Grievance, appeal, and request for state fair hearing information, or

h. Written notices informing members of their right to Interpretation and Translation services.

POLICY

A. Cultural Competency Plan

1. The AdSS shall have a comprehensive Cultural Competency program that includes Members with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity.
2. The AdSS shall develop a written Cultural Competency Plan (CCP) which includes measurable and sustainable goals.
3. The AdSS' CCP shall describe how care and services will be delivered in a culturally competent manner and shall include all information provided in ACOM Policy 405, Attachment A.

4. The AdSS shall identify a staff member responsible for implementation and oversight of all requirements for the Cultural Competency program and plan.
5. The AdSS shall require its workforce, as well as the workforce of their subcontractors, to adhere to all Cultural Competency requirements as specified in this policy.
6. The AdSS' CCP shall include:
    a. A description of methods used for evaluating the cultural diversity of its membership to assess needs and priorities to provide culturally competent care to its membership.
    b. An evaluation of the AdSS network, outreach services, and other programs to improve accessibility and quality of care for its membership.
    c. A description of the method(s) used for evaluating health equity and addressing health disparities within the AdSS' service delivery.
    d. A description of the provision and coordination needed for linguistic and disability-related services.

e. A description of Education and Training, which shall include:

i. Methods used to train workforce to ensure that services are provided in a culturally competent manner to members of all cultures.

ii. Customized training to fit workforce needs based on the nature of the contacts the AdSS workforce has with providers and or members.

iii. Cultural Competency training for the entirety of the workforce during new employee orientation and annually thereafter.

iv. Methods used for providers and other subcontractors with direct member contact, which shall include an education program designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner and understanding of health literacy.

v. Additional efforts to train or assist providers and subcontractors with how to provide culturally competent services.

f. The AdSS shall track participation of its workforce in Cultural Competency trainings.

B. TRANSLATION AND INTERPRETATION SERVICES

1. The AdSS shall ensure access to oral Interpretation, Translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request, and at no cost to the member.
2. The AdSS shall provide Translation and Interpretation services that are accurate, timely, and protect the privacy and independence of the individual with Limited English Proficiency (LEP).
3. The AdSS shall ensure Translation services are provided by a Qualified Translator, and Interpretation services shall be provided by a Qualified Interpreter.

a. The AdSS shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to use an adult accompanying the member with LEP for Interpretation in the following situations:

   i. When danger is imminent or there is a threat to the welfare or safety of the member, and there is no Qualified Interpreter immediately available; or

   ii. After receiving the AdSS' offer and recommendation to use a Qualified Interpreter, if the member with LEP still requests the accompanying adult to interpret or facilitate the communication, the accompanying adult agrees to provide the communication assistance, and reliance on the accompanying adult for assistance is reasonable under the circumstances.

b. The AdSS staff shall advocate for use of Qualified Interpretation services when an adult accompanying the member is providing communication assistance and:

i. There is a concern that the Interpretation is not accurate; or

ii. The content of the conversation is potentially inappropriate to be shared or provided with the accompanying adult.

c. The AdSS shall not permit reliance on a minor for Translation of any documents.

d. The AdSS shall only permit reliance upon minor children for Interpretation assistance when:

i. In an urgent emergency situation when danger is imminent, or there is a threat to the welfare or safety of the member, and

ii. There is no Qualified Interpreter immediately available.

e. The AdSS shall follow up with a Qualified Interpreter to verify information after the emergency is over, in the event that a minor child has been relied upon to provide Interpretation assistance.

4. The AdSS shall provide Translations and Interpretations in the following manner:
    a. Written member materials of all types shall be translated into Spanish regardless of whether or not the materials are vital.
        i. Vital Materials shall be made available in the prevalent non-English language spoken for each LEP population in the AdSS's service area.
        ii. Oral Interpretation services shall not substitute for written Translation of Vital Materials.
    b. Oral Interpretation services shall be made available at no cost to the member.
        i. This applies to sign language and all non-English languages, not just those identified as prevalent.
        ii. Information shall be made available on which providers speak languages other than English.

5. The AdSS shall provide member information materials in compliance with Division AdSS 404.
6. The AdSS shall provide written notices informing members of their right to Interpretation and Translation services free of charge.
7. The AdSS and its subcontractors shall:
    a. Use licensed interpreters for the Deaf and the Hard of Hearing; and
    b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request, which include:
        i. Computer-aided transcriptions,
        ii. Written materials,
        iii. Assistive listening devices or systems,
        iv. Closed and open captioning; and
        v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

8. The AdSS may contact the Arizona Commission for the Deaf and the Hard of Hearing for a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona.

C. CULTURAL COMPETENCY PLAN ASSESSMENT REPORTING

1. The AdSS shall assess its CCP for effectiveness to include modifications based on the assessment. The assessment shall consider:
   a. Linguistic need,
   b. Comparative member satisfaction surveys,
   c. Outcomes for certain cultural groups,
   d. Translation and Interpretation services and use,
   e. Member complaints and grievances,
   f. Provider feedback; and
   g. Employee surveys.
2. The AdSS shall track and trend identified issues, and identify actions taken to resolve the issue(s).

3. The AdSS shall address in the CCP how it communicates its progress in implementing and sustaining the CCP goals to all stakeholders, members and the general public.
4. The AdSS shall submit the CCP Assessment with ACOM 405 Attachment A.

D. LANGUAGE ACCESS PLAN

1. The AdSS shall submit a Language Access Plan with ACOM 405 Attachment A annually, that indicates how the needs of members with LEP are met.
2. The AdSS shall address each of the following elements in the Language Access Plan:
    a. Assessment: Needs and Capacity

        Processes to regularly identify and assess the language assistance needs of its members, as well as the processes to assess the AdSS's capacity to meet these needs according to the elements of this plan.

    b. Language Assistance Services

The AdSS shall provide the established point of contact for members who need Language Assistance Services. The AdSS shall include the process used to ensure that the interpreters used are qualified to provide the service and understand interpreter ethics and client confidentiality needs.

c. Written Translations

Processes to identify, translate, and make accessible in various formats, Vital Materials in accordance with assessments of need and capacity conducted as specified in assessment.,

d. Policies and Procedures

Written policies and procedures that ensure members with LEP have meaningful access to programs and activities.

e. Notification of the Availability of Language Assistance at no cost

Processes to inform members with LEP that language help is available at no cost. The AdSS shall take steps to ensure

meaningful access to its programs, including notifying current and potential members with LEP about the availability of free language help. Notification methods may include multilingual taglines in member materials, and statements on forms including electronic forms such as agency websites. The results as specified in the Needs and Capacity assessment above, should be used to determine the languages in which the notifications should be translated.

f. Workforce Training

Description of employee training to ensure management and staff understand and can implement the policies and procedures of the Language Access Plan.

g. Assessment: Access and Quality

Processes to regularly assess the accessibility and quality of language assistance activities for members with LEP, maintain an accurate record of Language Assistance

Services, and implement or improve LEP outreach programs and activities in accordance with customer need.

h. Stakeholder Consultation

Process for engaging stakeholder communities to:

i. Identify language assistance needs of members with LEP,

ii. Implement appropriate language access strategies to ensure members with LEP have meaningful access in accordance with assessments of member need; and

iii. Evaluate progress on an ongoing basis.

i. Subcontractor Assurance and Compliance

Processes for ensuring subcontractors understand and comply with their obligations under civil rights statutes and regulations enforced by the Arizona Health Care Cost Containment System (AHCCCS), related to language access.

E. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

The AdSS shall provide Family-Centered care in all aspects of the service delivery system for members with special health care needs. The additional responsibilities of the AdSS for support of Family-Centered care include :

1. Recognizing the family as the primary source of support for the member's health care decision-making process and making service systems and personnel available to support the family's role as decision makers.
2. Facilitating collaboration among members, families, health care providers, and policymakers at all levels for the:
    a. Care of the member,
    b. Development, implementation, evaluation of programs; and
    c. Policy development.
3. Promoting a complete exchange of unbiased information between members, families, and health care professionals in a supportive manner at all times.

4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
5. Implementing practices and policies that support the needs of members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
6. Participating in Family-Centered Cultural Competency Trainings.
7. Facilitating family-to-family support and networking.
8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
9. Acknowledging that families are essential to the members' health and well-being and are crucial allies for quality within the service delivery system.
10. Appreciating and recognizing the unique nature of each member and their family.

406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

REVISION DATE: 11/8/2023, 12/21/2022

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10, 42 CFR 438.102; ACOM 404-Attachment C; ACOM 406-Attachment A; ACOM 406-Attachment B;

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS). This policy establishes guidelines regarding Member handbooks and provider directories.

DEFINITIONS

1. "Business Day" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Long-Term Services and Supports" or "LTSS" means services and supports provided to Members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the

individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting as specified in 42 CFR 438.2.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "Multi-Specialty Interdisciplinary Clinic (MSIC)" means a facility where specialists from more than one specialty meet with Members and their families in order to provide interdisciplinary services to treat Members.
5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

A. GENERAL REQUIREMENTS,

1. The AdSS shall annually provide a Member Handbook to Members.

2. The AdSS shall annually provide a Provider Directory to Members,
3. The AdSS shall ensure the Member Handbook contains all information required, as identified in ACOM 406-Attachment A, including definitions as required by Centers for Medicare and Medicaid Services specified in ACOM 406-Attachment B.
4. The AdSS shall ensure required information is incorporated into the AdSS's Member Handbook in the order identified on the Checklist.
5. The AdSS shall submit the Member Handbook as described below in section B.
6. The AdSS shall publish information modifying or expanding the contents of the AdSS's Member Handbook, and distribute this information in the form of inserts and supply these inserts with subsequently distributed Member Handbooks when required by the Division.
7. The AdSS shall update paper provider directories at least quarterly.

8. The AdSS shall update electronic provider directories no later than 30 calendar days after receiving updated provider information.
9. The AdSS shall ensure the electronic versions of the Member Handbook and Provider Directory meet the following requirements:
    a. The format is readily accessible;
    b. The information is located in a place on the AdSS's website that is prominent and readily accessible and in a machine readable format which can be electronically retained and printed;
    c. The information is consistent with federal content and language requirements;
    d. The Member is informed that the information is available in paper form upon request at no cost and it is provided within five Business Days from the request; and
    e. The information adheres to the requirements identified in ACOM Policy 416.

10. The AdSS shall ensure language and format requirements are as outlined in Division Operations Policy 404.

B. MEMBER HANDBOOK REVIEW PROCESS

1. The AdSS shall submit to the Division its Member Handbook annually, along with a version reflecting changes from the previous contract year.
2. The AdSS shall also submit annually, a cover letter that includes the requirements as identified in ACOM 406-Attachment A, as specified in the contract or as directed by AHCCCS.
3. The AdSS shall submit a final copy of the Member Handbook to the Division after the Division has provided approval of a draft, as specified in the contract.

C. DISTRIBUTION REQUIREMENTS

1. Provider Directory
    a. The AdSS shall provide a Provider Directory to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.

b. The AdSS may provide the Provider Directory in hard copy format or written notification of how the Provider Directory information is available on the AdSS' website, via electronic mail, or via postal mailing.

i. The AdSS may include this notification in the Member Handbook, or mail the notice separately.

ii. The AdSS shall obtain approval for this notice in accordance with ACOM 404.

iii. The AdSS shall give the Member the option to obtain a hard copy version of the Provider Directory.

c. The AdSS shall acquire approval of the Member notification in accordance with Administrative Services Subcontractors Operations Manual, Policy 404.

2. Member Handbooks

a. The AdSS shall provide the Member Handbook to each Member or their Responsible Person within 12 Business Days of receipt of notification of the enrollment date.

b. The AdSS shall annually provide the Member Handbook, or notification of how to access the information in the Member Handbook, to each Member or their Responsible Person.

c. The AdSS shall provide written notification that the AdSS's Member Handbook is available on the subcontractor's website, upon request, via electronic mail or by postal mailing if required by the Division.

d. The AdSS shall make copies of the Member Handbook available to known consumer and family advocacy organizations and other human service organizations.

e. The AdSS shall update its Member Handbooks throughout the contract year when required by the Division to address program changes for inclusion, through inserts in the Member Handbook:

    i. These changes shall be incorporated in subsequently distributed handbooks through inserts until the handbooks are updated with the new information.

ii. The AdSS shall also post the content of the insert on the AdSS website.

D. PROVIDER DIRECTORY

1. The AdSS shall have a user-friendly, searchable, electronic Provider Directory, to include specialists for referrals, on the AdSS website.
2. The AdSS shall make available in an electronic and hard copy format a Provider Directory that meets the following requirements:
   a. Format is readily accessible and user friendly.
   b. Information is placed in a location on the AdSS's website that is prominent and readily accessible.
   c. Information is provided in an electronic form which can be electronically retained and printed.
   d. Information is consistent with federal content and language requirements.

e. Language and formatting comply with Division Administrative Services Subcontractors Operations Manual Policy 404.

3. The AdSS shall adhere to the requirements identified in AdSS Operations Policy Manual, Policy 416.

4. The AdSS shall ensure the Provider Directory, hard copy and electronic, includes:

   a. Provider name as well as any group affiliation;

   b. Provider address, ensuring virtual-only status is indicated for virtual-only providers in place of a physical address;

   c. Provider telephone number;

   d. Website Uniform Resource Locator (URL), as appropriate;

   e. Specialty, as appropriate;

   f. Non-English languages spoken;

   g. Whether or not the provider is accepting new patients;

   h. Information for the following provider types:

      i. Physicians, including specialists,

      ii. Hospitals,

iii. Pharmacies,

iv. Behavioral Health Providers,

v. Long-Term Services and Supports (LTSS) Providers, as applicable,

vi. Community-based, peer and family support providers throughout the State; and

vii. Multi-Specialty Interdisciplinary Clinic (MSIC)s.

i. Provider's cultural and linguistic capabilities, including languages, including American Sign Language, offered by the provider or a skilled medical interpreter at the provider's office;

j. Locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract;

k. A designation for identifying network offices that offer reasonable accommodations for Members such as:

i. Physical access,

ii. Accessible equipment; and

iii. Culturally competent communications and a description of how the Members can obtain details of the accommodations for specific providers.

l. Innovative service delivery mechanisms such as field clinics, virtual clinics, and an Integrated Medical Record to provide MultiSpecialty, Interdisciplinary Care (MSIC) when needed in other areas of the State;

m. Information on the services, offered through telemedicine and mobile providers, and how to access these services; and;

n. Physicians, psychiatrists, laboratory, x-ray, and therapy services available onsite at the MSIC.

407 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: AHCCCS Contractor Operations Manual (ACOM) Policy 407

INTENDED USERS: Division's Administrative Services Subcontractors (AdSS)

DELIVERABLES: Workforce Development Plan

PURPOSE

The purpose of this policy is to describe the AdSS requirements to establish and maintain a Workforce Development Operations (WFDO) to:

1. Monitor and collect information about the workforce;
2. Collaboratively plan workforce development initiatives; and
3. When necessary, provide direct assistance to providers to develop the workforce development plans.

DEFINITIONS

1. "Competency" means a worker's demonstrated ability to intentionally, successfully, and efficiently perform the basic requirements of a job multiple times, at or near the required standard of performance.

2. "Competency Development" means a systematic approach for ensuring workers are adequately prepared to perform the basic requirements of their jobs.
3. "Network Workforce Development Plan (WFD-P)" means the AdSS's blueprint for ensuring the ongoing growth and development of the network's workforce.
4. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
5. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
6. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and or connecting workers to information.
7. "Workforce Development Alliance (WFDA)" means a coalition of the WFD Administrators from each Managed Care Organization

(MCO) that jointly plan and conduct WFD activities for a particular line of business.

8. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources that the AdSS implements, including monitoring and assessing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to strengthen their WFD programs.

POLICY

A. GENERAL

1. The AdSS shall work with the Division, AHCCCS, and providers to ensure members receive services from a workforce that is qualified, capable, and sufficiently staffed.
2. The AdSS shall:
   a. Acquire, develop, and deploy a sufficiently staffed and qualified workforce that capably delivers services to members;
   b. Oversee the development of the provider workforce;

c. Establish workforce development policies including worker and workplace practices, that aligned with Division policies;

d. Analyze current and future healthcare trends, and forecast the workforce capacities and competencies needed to address these trends;

e. Ensure that workforce and development processes are aligned with the Division's workforce and workforce development policies;

f. Monitor the performance of its network, collect information about the workforce, develop plans to strengthen the workforce, and directly assist providers to develop and maintain a qualified, capable, and sufficiently capacitated workforce; and

g. Assist the Division with developing forecasting and plans concerning the WFD needs of Arizona's healthcare system.

3. The AdSS shall ensure that subcontracted provider organizations are:

a. Deploying a qualified, sufficiently staffed workforce;

b. Providing services to members eligible for the Division in an interpersonally, clinically, culturally, and technically effective manner; and

c. Offering training and resources to assist professionals and family caregivers with managing stress and burnout as required by the Report of the Abuse & Neglect Prevention Task Force.

B. ESTABLISH AND MAINTAIN A WORKFORCE DEVELOPMENT OPERATION

The AdSS shall:

1. Establish and maintain a WFDO that shall work together with Network Management, Quality Management, and Cultural Competency programs to ensure the workforce has the capacity needed to provide services and the diversity and capability required to competently deliver them.
2. Name a Workforce Development Administrator to lead the WFDO who shall:

a. Manage the AdSS's network specific process of continuous workforce quality development and improvement; and

b. Have a professional background, authorities, and ongoing training and development needed to lead the WFDO as specified in the AdSS contract.

3. Equip the WFDO with the organizational personnel and information processing support required to execute the following responsibilities of the WFDO:

a. Monitor and assess current workforce capacity and capability;

b. Forecast and plan future or needed workforce capacities and capabilities,

c. Deliver technical assistance to its workforce to strengthen their WFD programs;

d. Monitor, assess, forecast, plan, and provide technical assistance both independently and in coordination with WFDOs of the other MCOs to:

i. Independently act on the workforce needs of its network as identified by the AdSS's network and quality management departments; and

ii. Work closely with the Division and other MCOs to:

1) Achieve statewide system and industry specific WFD goals;

2) Ensure that WFD processes, such as system-wide orientation and training programs, are uniformly applied; and

3) Prevent the miscommunication of WFD priorities as well as mitigate administrative burden associated with developing the workforces of the statewide workforce community.

4. Ensure its workforce has access to, and is in compliance with, all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, Division policies, guidance documents, manuals, contracts, and other AdSS plans.

5. Ensure its workforce has access to all the resources necessary to engage designated audiences and satisfy the WFD requirements as specified in AHCCCS policies, Division policies, guidance documents, manuals, contracts, and other AdSS plans.

C. NETWORK WORKFORCE DEVELOPMENT PLAN

1. The AdSS shall produce a Network Workforce Development Plan (WFD-P) as specified in ACOM 407 and ACOM 407 Attachment A.
2. The AdSS shall ensure the WFD-P:
   a. Determines areas where, relative to network and quality requirements, specific increases in workforce capacity, worker competency and capability are needed;
   b. Determines if the WFD programs of a single provider, or the WFD programs of the provider network, for acquiring, developing, and maintaining a sufficiently staffed, diverse, and capable workforce should be enhanced to ensure compliance with the AdSS's network and quality requirements; and

c. Develops and implements a plan of action designed to increase and improve workforce capacity and capability by working collaboratively with providers to develop the workforce and enhance their current WFD programs.

3. The AdSS shall include as part of the Network WFD-P, but is not limited to, the following components:
   a. Description of the AdSS WFDO;
   b. Workforce Profile;
   c. Workforce Capacity Assessment, Development Goals, Work plan; and
   d. Workforce Capability/Competency Assessment, Development Goals, and Work plan.
4. The AdSS shall develop the WFD-P in collaboration with:
   a. Providers,
   b. AHCCCS members and their families; and
   c. Other stakeholders, including but not limited to:
      i. Other Contractors and industry;
      ii. Education; and

iii. Community groups.

5. The AdSS shall submit the Network WFD-P as specified in the AdSScontract.

D. MONITOR PROVIDER WORKFORCE DEVELOPMENT ACTIVITIES

As part of the routine audit and compliance monitoring process, the AdSS shall ensure:

1. The provider workforce has access to, and is in compliance with all workforce training and competency requirements specified by federal and state law, AHCCCS and Division policies, guidance documents, manuals, and other AdSS plans.
2. All AHCCCS required training content and competency descriptions are incorporated into the appropriate orientation, basic, specialized, or advanced levels of education or training program and evaluation processes and are made available to provider personnel.
3. Providers have processes for:
   a. Documenting training;

b. Verifying the qualifications, skills, and knowledge of personnel; and

c. Retaining required training and competency transcripts and records.

4. All initiatives specified in the Network WFD-P are routinely monitored and evaluated.

E. WORKFORCE DATA

1. The AdSS shall collect and analyze required and ad hoc workforce data that:

   a. Proactively identifies potential challenges and threats to the viability of the workforce,

   b. Conducts analysis of the potential impact of the challenges and threats to access to care for members,

   c. Develops and implements interventions to prevent or mitigate threats to workforce viability, and

   d. Develops indicators to measure and monitor workforce sustainability.

2. The AdSS shall use the collected data to directly assist the Division and AHCCCS WFD Administrator develop a comprehensive workforce assessment and forecast of WFD priorities.

F. PROVIDER TECHNICAL ASSISTANCE

1. The AdSS shall determine the need, scope, and the most effective and efficient methods for providing technical assistance to providers.
2. As needed, the AdSS shall provide technical assistance to providers to develop, implement, and improve programs for workforce recruitment, selection, evaluation, education, training, and retention that may include:
    a. Workforce development planning,
    b. Talent identification and acquisition,
    c. Competency based training and development programs and systems,
    d. Workforce retention and promotion strategies, and
    e. Workplace culture development.

408 SANCTIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §36-2903.01(B)(4); 42 CFR 438.700 et sq.

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy specifies the sanctions that may be imposed by the Division o in accordance with federal and state laws, regulations and the contract with the Division. This policy does not limit the authority of the Division or AHCCCS Office of the Inspector General to investigate fraud, waste and abuse, conduct audits, and pursue any legal remedies arising from the findings of those investigations and audits.

Definitions

A. Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the AdSS and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency

B. Notice to Cure (NTC) - A formal written notice to an AdSS regarding specific non-compliance. The NTC contains specific timelines for meeting performance standards and possible penalties for continued non-compliance. An NTC may contain specific activities or reporting requirements that must be adhered to as the AdSS works toward compliance. Failure to achieve compliance as the result of a Notice to Cure may result in the imposition of a Sanction

C. Sanction - A monetary and/or non-monetary penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility. Non-monetary penalties may include, but are not limited to any or all the following:

1. Appointment of temporary management for the AdSS, granting the AdSS enrollees the right to terminate enrollment with the AdSS

2. Suspension of auto-assignment and/or new enrollment

3. Suspension of payment to the AdSS until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

General

The Division expects the AdSS to align its performance of the Contract with the AHCCCS and Division mission and vision and implement program innovation and best practices on a continual basis while adding value to the ALTCS program.

If the AdSS fails to demonstrate compliance with contractual requirements, the Division may elect to impose an administrative action. The Division reserves the right to issue an administrative action for any occurrence of non-compliance. Each occurrence of non-compliance will be evaluated for determination and issuance of potential administrative

action. Administrative actions may include issuance of any or all the following: Notice of Concern, Notice to Cure, a mandate for a Corrective Action Plan, and Sanctions. The administrative actions described in this policy are non-exclusive; that is, the issuance of an administrative action or the imposition of any sanction by the Division does not preclude the Division from pursuing any other remedy available in law or contract arising from the same conduct.

To promote transparency, administrative actions and related documentation may be published on the Division website.

Division Compliance Committee

A. Except for encounter-related sanctions for aged, pended encounters as outlined in the Division Encounter Manual, the Division Compliance Committee will evaluate recommendations for proposed sanctions and will determine the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee, however, will regularly review encounter-related sanctions to ensure just and consistent application of such sanctions. The Compliance Committee may, but is not required to, review administrative actions that do not include a sanction such as issuing a Notice of Concern, a Notice to Cure, or requiring a Corrective Action Plan.

B. The Division's Health Plan Compliance Committee is comprised of the following individuals, or their designees:

- Medical Director
- Compliance Officer
- Quality Management Manager
- Performance/Quality Improvement Coordinator
- Maternal Child Health/EPSDT Coordinator
- Medical Management Manager
- Network Manager
- Behavioral Health Coordinator
- Policy Manager

C. All Compliance Committee members listed above, or their designee, must be present at each Committee meeting. Sanctions will be approved based on a majority vote.

D. The Division's Health Plan Compliance Committee may consult with subject matter experts as appropriate and will consider the following in its decision making:

1. Applicable statutes and rules and contractual requirements

2. Application of consistent standards for determination of sanction type administrative actions

3. The goals and objectives of the agency

4. Aggravating or mitigating factors such as:

a. Quality of care or safety concerns for members

b. Repeated/continual deficiencies

c. Previous administrative actions

d. Intentional non-compliance

e. Self-identification of deficiencies and remediation

f. Risk to the financial viability of the AdSS

g. Non-compliance with key staffing requirements

h. Financial implications for providers,

i. Financial harm to the state.

E. Upon the Committee's decision regarding the sanction, the Division will provide written notification to the AdSS which explains the basis and nature of the sanction, and any applicable appeal rights [42 CFR 438.710(a)(1)].

Basis for Imposition of Sanctions

The Division may impose sanctions for any breach of the Contract, or any failure to comply with applicable state or federal laws or regulations including but not limited to any conduct described in 42 CFR 438.700 et seq.

Types of Sanctions

The Division may impose the following types of sanctions:

A. Member Enrollment Related Sanctions

the Division may sanction an AdSS by:

1. Granting members, the right to terminate enrollment without cause and notifying the affected members of their right to disenroll (If another AdSS is available)

2. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction (if another AdSS is available)

3. Suspending payment for members enrolled after the effective date of the sanction until CMS or the Division is satisfied that the reason for the sanction no longer exists and is not likely to recur.

Right to Appeal

The AdSS may file a grievance to dispute the decision to impose a sanction in accordance with A.R.S. §36-2903.01(B)(4).

Sanctions Imposed to AdSS

A. Sanctions imposed against the Division by AHCCCS for noncompliance with requirements for encounter data or reporting that would not have been imposed but for the AdSS action or lack thereof will be assessed to the AdSS as actual damages.

B. Any other sanctions imposed against the Division by AHCCCS in accordance with applicable AHCCCS rules, policies, and procedures that would not have been imposed but for the AdSS action or lack thereof will be assessed dollar for dollar to the Contractor as actual damages.

C. Sanctions imposed against the Division by AHCCCS for failure of AdSS to submit requested disclosure statements will be assessed dollar for dollar to the AdSS as actual damages.

412 CLAIMS RECOUPMENT

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2901, 35-214; A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq.; Deficit Reduction Act of 2005 (Public Law 109-171); 42 CFR 438.600 et seq.

DELIVERABLES: Claim Recoupments >12 Months from Original Payment; Data Processes for Recoupments; Single Claim Recoupments >$50,000

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It outlines the guidelines for claims recoupment and refund activities.

AdSS are responsible for reimbursing their providers and coordinating care for services provided to a member pursuant to state and federal regulations.

Definitions

A. Day - Calendar day unless otherwise specified.

B. Provider - Any person or entity that contracts with the AdSS for the provision of covered services to members according to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a provider delivering such services.

C. Recoupment - An action initiated by the AdSS to recover all or part of a previously paid claim(s). Recoupments include AdSS initiated/requested repayments, as well as overpayments identified by the provider where the AdSS seeks to actively withhold or withdraw funds to correct the overpayment from the provider. For purposes of this policy, a recoupment is a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days. An adjustment that is greater than $50,000 and is completed within 30 days is not considered a recoupment but must be tracked and made available to the Division upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

D. Refunds - An action initiated by a provider to return an overpayment to the AdSS. In these instances, the provider writes a check or transfers money to the AdSS directly.

Recoupments Over $50,000 Or One Year

A. Single Recoupment in Excess of $50,000

Prior to initiating any single recoupment in excess of $50,000 per provider Tax Identification Number (TIN), the AdSS must submit a written request for approval to the Division Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation that describes:

   a. How the need for recoupment was identified

b. The systemic causes resulting in the need for a recoupment

c. The process that will be used to recover the funds

d. Methods to notify the affected provider(s) prior to recoupment

e. The anticipated timeline for the project

f. The corrective actions that will be implemented to avoid future occurrences

g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted

h. Other recoupment action specific to this provider within the contract year.

2. An electronic file containing:

a. AHCCCS member ID

b. Date of service

c. AHCCCS original claim number

d. Date of payment

e. Amount paid

f. Amount to be recouped.

3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include, at a minimum:

a. How the need for the recoupment was identified

b. The process that will be used to recover the funds

c. The anticipated timeline for the recoupment

d. The provider's right to file a claim dispute

e. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped

f. Listing of impacted claim numbers.

The written communication must be approved by Division prior to being sent to the provider(s).

B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment

The AdSS is prohibited from initiating recoupment of monies from a provider TIN more than 12 months from the date of original payment of a clean claim unless approval is obtained from the Division. Retroactive third party recoveries for Third Party Liability (TPL) are not included in this discussion.

To request approval from the Division, the AdSS must submit a request in writing to the designated Division Compliance Officer with all the following information:

1. A detailed letter of explanation that describes:
    a. How the need for the recoupment was identified
    b. The systemic causes resulting in the need for recoupment
    c. The process that will be used to recover the funds
    d. Methods to notify the affected provider(s) prior to recoupment
    e. The anticipated timeline for the project
    f. The corrective actions that will be implemented to avoid future occurrences
    g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted.
2. An Electronic file containing:
    a. AHCCCS member ID
    b. Date of service
    c. AHCCCS original claim number
    d. Date of payment
    e. Amount paid
    f. Amount to be recouped.
3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include at a minimum:
    a. How the need for the recoupment was identified
    b. The process that will be used to recover the funds
    c. The anticipated timeline for the recoupment
    d. Total recoupment amount, total number of claims, and ranges of dates for the claims being recouped
    e. Listing of impacted claim numbers.

The written communication must be approved by the Division prior to being sent to the provider(s).

C. Cumulative Recoupment in Excess of $50,000 per Contract Year

The AdSS must continuously track recoupment efforts per provider TIN. When recoupment amounts for a provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the AdSS must report the cumulative recoupment monthly to the designated Division Compliance Officer as outlined in the Division Claims Dashboard Reporting Guide.

414 REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICE OF ADVERSE BENEFIT DETERMINATION

REVISION DATES: 06/28/2023, 7/28/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: Section F3, Contractor Chart of Deliverables; 42 CFR 438; 42 CFR 431.211; 42 U.S.C. 1396d(r)(5); A.A.C. R9-34-202, A.A.C. R9-22-213; ACOM Policy 414-Attachments A, B, and C

PURPOSE

This policy sets forth the Division's Administrative Services Subcontractors (AdSS) requirements for service authorization decisions and a Notice of Adverse Benefit Determination relating to Title XIX/XXI coverage of services. The AdSS shall follow all other requirements regarding a Notice of Adverse Benefit Determination set forth in Contract and referred to as a Notice of Adverse Benefit Determination throughout.

DEFINITIONS

1. "Adverse Benefit Determination" means the denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.
2. "Appeal" means a request for review of an Adverse Benefit Determination.
3. "Calendar Days" means every day of the week including

weekends and holidays.

4. "Expedited Service Authorization Request" means a request for services in which either the requesting provider indicates, or the Division determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.
5. "Legal Holidays" means Legal Holidays, as defined by the State of Arizona are:
    a. New Year's Day – January 1
    b. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January
    c. Lincoln/Washington Presidents' Day – 3rd Monday in February
    d. Memorial Day – Last Monday in May
    e. Independence Day – July 4
    f. Labor Day – 1st Monday in September
    g. Columbus Day – 2nd Monday in October
    h. Veterans Day – November 11

i. Thanksgiving Day – 4th Thursday in November

j. Christmas Day – December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

6. "Member" means the same as "Client" as defined in A.R.S. §36-551.
7. "Notice of Adverse Benefit Determination" means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the AdSS regarding the service authorization request and includes the information required by this Policy.
8. "Notice of Extension" or "NOE" means a written notice to a Member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.
9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental

disability who is a member or an applicant for whom no guardian has been appointed.

10. "Service Authorization Request" means a request by the Member, the representative, or a provider for a physical or behavioral health service for the Member that requires Prior Authorization (PA) by the AdSS.

11. "Working Days" means "Working Day" as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:

    a. A legal holiday falls on one of these days; or

    b. A legal holiday falls on Saturday or Sunday and the Division is closed for business the prior Friday or following Monday.

POLICY

A. NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The AdSS shall provide a written Notice of Adverse Benefit Determination to the Responsible Persons described in 42 CFR 438.404, when the AdSS decides to deny or limit an authorization request or reduce, suspend, or terminate

previously authorized services.

2. The AdSS shall use the AHCCCS-developed Member Notice of Adverse Benefit Determination templates specified in 42 CFR 438.10(c)(4)(ii).
   a. The templates shall not be altered except for the areas designated in the template that permit alteration and the removal of the header.
   b. Refer to ACOM Policy 414 Attachment A for the Notice of Adverse Benefit Determination template.
3. The AdSS shall provide a Member Handbook that informs the Responsible Person:
   a. Of their right to make a complaint to the AdSS about an inadequate Notice of Adverse Benefit Determination.
   b. If the AdSS does not resolve the complaint about the Notice of Adverse Benefit Determination to the Responsible Person's satisfaction, the Responsible Person may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at: MedicalManagement@azahcccs.gov, and
   c. That the AdSS and its providers shall be prohibited from

taking punitive action against Responsible Persons exercising their right to Appeal.

d. That the AdSS shall inform the Responsible Person that oral interpretation services are available in any language, and alternative communication formats are available for Responsible Persons that are deaf or hard of hearing or blind or have low vision.

B. RIGHT TO BE REPRESENTED

1. The AdSS shall acknowledge the Responsible Person's right to be assisted by a third-party representative, including an attorney, during an Appeal of an Adverse Benefit Determination.
2. The AdSS shall have an Appeals process that registers the existence of the third party representative.
3. The AdSS shall ensure the required communications related to the Appeals process occur between the AdSS and the third party representative.
   a. The AdSS shall provide the Responsible Person's third party representative, upon request, timely access to documentation relating to the decision at Appeal.
   b. The AdSS shall be consistent with federal privacy laws, by

making reasonable efforts to verify the identity of the third party representative and the authority of the third party representative to act on behalf of the Responsible Person. The AdSS may require the third party representative to provide a written authorization signed by the Responsible Person.

c. The AdSS shall promptly communicate to the third party representative when the AdSS questions the authority of the third party representative or the sufficiency of a written authorization.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

1. The Adss shall provide a Notice of Adverse Benefit Determination that meets the language requirements as outlined in AdSS Operations Policy 404.
2. The AdSS shall provide a Notice of Adverse Benefit Determination that clearly explains the Member specific reason for the AdSS' determination and the information needed so the Responsible Person can make an informed decision regarding Appealing the determination, and how to Appeal the decision.

3. The AdSS shall clearly inform the Responsible Person when the reason for the denial of a Service Authorization Request is due to the lack of necessary information and will give the Responsible Person the opportunity to provide the necessary information.
4. The AdSS shall provide a Notice of Adverse Benefit Determination that is consistent with 42 CFR 438.404 which includes an explanation of the specific facts that pertain to the decision:
    a. The requested service;
    b. The level of service which may include a request for an enhanced staffing ratio.
    c. The reason or purpose of the requested service;
    d. The reasons for the Adverse Benefit Determination the AdSS made or intends to make with respect to the requested service consistent with 42 CFR 438.404(b)(1);
    e. The effective date of a service denial, limited authorization, reduction, suspension, or termination;
    f. The right of the Responsible Person to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information

relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2);

g. The legal basis for the Adverse Benefit Determination including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable, reference to the general legal authorities alone is unacceptable;

h. Where the Responsible Person can find copies of the legal basis including.

i. Reference to the benefit provision, guideline, protocol, or other criterion which the denial is based upon;

ii. An accurate URL site, when a legal authority or an internal reference to the AdSS' policy manual is available online, to enable the Member to find the reference online;

i. A listing of legal aid resources;

j. The Responsible Person's right to request an Appeal and procedures for filing an Appeal of the AdSS Adverse Benefit Determination, including information on exhausting the AdSS' Appeals process described in 42 CFR 438.402(b) and the right to request a state fair hearing consistent with 42 CFR 438.402(c) including when the AdSS fails to make a decision in a timely manner regarding the Member's Appeal request;

k. The procedures for exercising the Responsible Person's rights as described in 42 CFR 438.404(b)(4);

l. The circumstances under which an Appeal process can be expedited and how to request it; and

m. Explanation of the Responsible Person's right to have benefits continue pending the resolution of the Appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Responsible Person may be required to pay the costs of continued services if the Appeal is denied as specified in 42 CFR 438.420(d).

n. A statement that the provider who requested the Service

Authorization Request has the option to request a peer-to-peer discussion with the AdSS' Medical Director.

i. The AdSS shall allow the provider sufficient time for a peer-to-peer to occur before the AdSS issues its decision regarding the service authorization request.

ii. The AdSS shall allow at least 10 business days for the provider to request a peer-to-peer.

5. The AdSS shall not cite the lack of medical necessity as a reason for denial, unless the Notice of Adverse Benefit Determination also provides a complete explanation for the particular Member in this instance.

6. The AdSS shall include potential alternative options for consideration that may address the Member's condition when citing lack of medical necessity as a reason for the Adverse Benefit Determination.

7. The AdSS shall utilize a board-certified professional when citing lack of medical necessity and provide evidence of such upon AHCCCS request.

8. The AdSS shall provide a Notice of Adverse Benefit Determination that states the reasons supporting the denial,

reduction, limitation, suspension, or termination of a service.

9. The AdSS shall not provide a Notice of Adverse Benefit Determinations that does not give an explanation of why the service has been denied, reduced, limited, suspended, or terminated and merely refer the Responsible Person to a third party for more information.

10. The AdSS shall include a statement referring a Responsible Person to a third party for more help when the third party can explain treatment alternatives in more detail.

D. EPSDT

1. The AdSS shall cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX Member who is younger than 21 years of age when these provisions are applicable and shall specify the reason(s) why the service fails to correct or ameliorate defects or physical or behavioral health conditions or illnesses.

2. The AdSS shall explain the denial, reduction, limitation, suspension, or termination of the requested EPSDT service in accordance with AMPM 430 and this Policy.

3. The AdSS shall specify why the requested service does not meet the EPSDT criteria and is not covered.
4. The AdSS shall also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

E. RESPONSIBLE PERSON COMPLAINTS REGARDING THE ADEQUACY OR UNDERSTANDABILITY OF THE NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The AdSS shall review the initial Notice of Adverse Benefit Determination against the content requirements of this Policy when a Responsible Person complains about the adequacy of a Notice of Adverse Benefit Determination.
2. The AdSS shall issue an amended Notice of Adverse Benefit Determination consistent with the requirements of this Policy when the AdSS determines that the original Notice of Adverse

Benefit Determination is inadequate or deficient.

3. The AdSS shall begin the timeframe for the Responsible Person to Appeal and continuation of services shall start from the date of the amended Notice of Adverse Benefit Determination when an amended Notice of Adverse Benefit Determination is required.

F. TIMEFRAMES FOR SERVICE AUTHORIZATION DECISIONS

All references to "days" in this Policy mean "Calendar Days" unless otherwise specified.

1. The AdSS shall ensure completion and issuance of the Service Authorization Request decision when a Service Authorization Request is submitted, within the following timeframes,standard requests, expedited requests, and whether the Service Authorization Requests relates to medications.
   a. The AdSS shall consider the date and time the AdSS or the Division receives the request to be considered the date and time of receipt, whichever is earlier, to be considered the date and time of receipt.
   b. The AdSS shall use the date and time to determine the due date for completion of the authorization decision,

depending on the timeframe applicable to the particular type of service request. The AdSS shall use electronic date stamps or manual stamping for logging the receipt.

2. The AdSS shall make sufficient attempts to obtain the information or clarification and document all attempts for Service Authorization Requests lacking sufficient clinical information necessary to render the decision or the required clarification.
3. The AdSS shall have a process for standard and Expedited Service Authorization Requests that do not involve medications. Service authorization decisions pertaining to requests for medication shall be completed within the timeframe specified below and do not follow the standard or expedited timeframes used for other Service Authorization Requests.
4. The AdSS shall prioritize the authorization decision and make the determination within the 72-hour Expedited Service Request timeframe as described in this section for Expedited Service Requests that meet these requirements.
5. A Standard Authorization Request is a request for a service that is not medication and does not meet the definition of an Expedited Service Authorization Request. For standard Service

Authorization Requests, the date the AdSS receives the request is considered the date of receipt and is used to determine the due date for completion of the decision for standard Service Authorization Request.

6. The AdSS shall use the date and time the request is received to determine the completion time for the decision for an Expedited Service Authorization Request and medication requests.
7. Service Authorization Decision Timeframe for Medications:
    a. The AdSS shall issue service authorization decision for medication no later than 24 hours from receipt of the submitted request for prior authorization regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.
    b. The AdSS shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request when the prior authorization request lacks sufficient information for the AdSS to render a decision for the medication.
    c. The AdSS shall issue a final decision no later than seven

working days from the initial date of request. Refer to 42 CFR 438.3(s).

2. Standard authorization decision timeframe for Service Authorization Requests that do not pertain to medications:
   a. The AdSS shall issue service authorization decisions as expeditiously as the Member's condition requires but no later than 14 Calendar Days from receipt of the request for the service regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.
   b. The AdSS shall issue a Notice of Extension of up to 14 additional Calendar Days , utilizing ACOM 414 Attachment C, when the criteria for a service authorization extension are met as specified in section (H) of this Policy.
3. The AdSS shall treat the following Service Authorization Requests as an expedited request.
   a. Behavioral Health Residential Facility (BHRF)
   b. Determination for Member participation in a clinical trial shall be treated as an expedited request regardless the location or if the provider is in-network, and

c. Requests for services when a Member is awaiting disposition into an emergency department.

4. Expedited service authorization decision timeframe for Service Authorization Requests that do not pertain to medications:

a. The AdSS shall issue an expedited service authorization decision as expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

b. The AdSS shall issue a Notice of Extension (NOE) of up to 14 additional Calendar Days, utilizing ACOM 414 Attachment C, when the criteria for a service authorization extension are met as specified in this Policy.

5. Expedited Service Authorization Request treated as a Standard Authorization Request:

a. The AdSS shall treat the Expedited Service Authorization Request as a Standard Authorization Request when the

Service Authorization Request fails to meet the requirements for an expedited consideration.

b. The AdSS shall have a process included in the AdSS' policy for prior authorization that describes how the Responsible Person shall be notified of the change to a Standard Authorization Request and be given an opportunity to provide additional information.

c. The AdSS shall permit the requesting provider to send additional documentation supporting the need for an Expedited Service Authorization.

6. Service authorization decisions not reached within the timeframes:

a. The AdSS shall consider a Service Authorization Request decision that is not reached within the required timeframes for a standard, or expedited request, as a denial when the AdSS has not made a decision.

b. The AdSS shall issue a Notice of Adverse Benefit Determination denying the request on the date that the timeframe expires.

7. Service authorization decisions not reached within the extended

timeframes:

a. The AdSS shall consider a service authorization decision that is not reached within the timeframe noted in the NOE as a denial.

b. The AdSS shall issue a Notice of Adverse Benefit Determination denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

G. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

1. The AdSS shall mail the Notice of Adverse Benefit Determination within the following timeframes:

   a. For termination, suspension, or reduction of a previously authorized service, the Notice of Adverse Benefit Determination shall be mailed at least 10 Calendar Days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice [42 CFR 431.211, 42 CFR 438.404(c)(1)].

   b. For standard service authorization decisions that deny or limit services, the AdSS shall provide a Notice of Adverse

Benefit Determination:

i. No later than 24 hours from the receipt of the request for authorization of medication regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona. When the prior authorization request for a medication lacks sufficient information from the prescriber no later than 24 hours from receipt of the request. A final decision and a Notice of Adverse Benefit Determination shall be rendered no later than seven Working Days from the initial date of the request.

ii. For a non-medication request for authorization, as expeditiously as the Member's health condition requires but no later than 14 Calendar Days from the receipt of the request, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless there is a NOE. For the NOE timeframes, refer to NOE requirements in this Policy [42 CFR

438.404(c)(3) and (4), 42 CFR 438.210(d)(1)].

iii. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless there is a NOE. Refer to NOE Requirements in section (H) of this Policy for NOE timeframes.

iv. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless there is a NOE. For extension timeframes, refer to NOE Requirements in this Policy.

H. NOTICE OF EXTENSION (NOE) REQUIREMENTS

1. Notice of Extension (NOE) timeframes:
    a. The AdSS shall extend the timeframe to make a service authorization decision for both standard and Expedited Service Authorization Requests when the Responsible Person or provider, with the written consent of the Responsible Person, requests an extension, or
    b. The AdSS shall document all attempts made to the requesting provider for the needed information.
    c. The AdSS shall notify the Responsible Person of the reason for the extension and attempt to obtain the Member's approval before the AdSS pursues an extension due to lack of sufficient clinical information.
2. The AdSS shall not pursue the NOE until the AdSS has made sufficient attempts to first obtain the necessary information from the Responsible Person within the standard or expedited timeframe, whichever is applicable. 42 CFR 438.404(c)(4) and 438.210(d).
3. The AdSS shall document all attempts made to the requesting provider for the needed information.

4. The AdSS shall notify the Member of the reason for the extension and attempt to obtain the Responsible Person's approval before the AdSS pursues an extension due to lack of sufficient clinical information.
5. The AdSS shall not send the NOE until the AdSS has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)];
    a. For Standard Service Authorization Requests, the AdSS may extend the 14 Calendar Day timeframe to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the service request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona;
    b. For an Expedited Service Authorization Request, the AdSS may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of

Arizona;

c. When the AdSS justifies the need for additional information is in the Member's best interest. The NOE shall not be sent until the AdSS has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)].

d. For standard Service Authorization Requests, requests that do not involve medications, the AdSS may extend the 14 Calendar Day timeframe to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the Service Authorization Request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

e. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations (F)(6) in this Policy when the prior authorization requests lack sufficient information from the prescriber.

f. For an Expedited Service Authorization Request, requests

that do not involve medication, the AdSS may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

6. When the AdSS extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210(d)(1) the AdSS shall:
   a. Provide the Responsible Person with written notice of the reason for the decision to extend the timeframe, including what information is needed in order to make a decision, and in easily understood language, refer to Division Operations Policy 404;
   b. Inform the Responsible Person of the right to file a grievance (complaint) when the Responsible Person disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and
   c. Issue and carry out the decision as expeditiously as the Member's condition requires and no later than the date the

NOE expires consistent with 42 CFR438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii).

I. NOTICE OF ADVERSE BENEFIT SELF-MONITORING REQUIREMENT

1. The AdSS shall audit Notice of Adverse Benefit Determinations that have been issued as outlined below:
   a. Utilizing the AHCCCS provided Reporting Form;
   b. Reporting Notice of Adverse Benefit Determinations issued within the quarter prior;
   c. Report the Division's line of business when submitting the Scores and Summary described below;
   d. The auditor shall not be a staff member that writes or issues the Notice of Adverse Benefit Determination;
   e. The sample includes a Notice of Adverse Benefit Determinations from each of the following categories:
      i. Medical,
      ii. Dental,
      iii. Pharmacy, and
      iv. Behavioral Health
   f. The AdSS shall randomly select 30 Notice of Adverse

Benefit Determinations from each of the categories;

i. The AdSS shall randomly select eight From the 30 to be audited.

ii. The AdSS shall not audit the remaining 22 Notice of Adverse Benefit Determinations when the initial eight Notice of Adverse Benefit Determinations are all found to be in compliance, 95% or above;

iii. The AdSS shall audit the remaining 22 Notice of Adverse Benefit Determinations when any one of the eight Notice of Adverse Benefit Determinations issued are found to be out of compliance.

g. The AdSS shall submit a Notice of Adverse Benefit Determination Self-Audit Scores and Executive Summary to the Division as specified in the Contract.

2. The AdSS shall provide an Executive Summary that includes an analysis of the audit including:

a. A methodology for pulling the sample,

b. Deficiencies,

c. Plan of action to bring back into compliance,

d. Staff member involved in audit and credentials or role in

the organization, and

e. Score sheet

3. The AdSS shall submit a Notice of Adverse Benefit Determination Self-Audit Scores and Executive Summary to the Division as specified in the Contract.

4. The Division shall reserve the right to request specific Notice of Adverse Benefit Determinations and associated records for further review.

415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

REVISION DATE: 1/17/2024, 3/22/2023, 1/26/2022

REVIEW DATE: 10/10/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 415, 417, and 439; ACOM 415 Attachments A, B, D, F; 9 A.A.C. 22, Articles 1 and 2; A.R.S. §§ 36-2901, 36-3407; 42 CFR 457.1230, 42 CFR 438.207(b), Section F3, Contractor Chart of Deliverables

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes AdSS requirements for the submission of the Network Development and Management Plan and other periodic reporting requirements.

DEFINITIONS

1. "Attachment" means attachment to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) 415.
2. "Contract" means the Division's contract with AdSS.

POLICY

A. NETWORK DEVELOPMENT AND MANAGEMENT PLAN

1. The AdSS shall develop and maintain a Provider Network Development and Management Plan (NDMP), which assures the Division that the provision of covered services will occur as stated in the Contract [42 CFR 457.1230, 42 CFR 438.207(b)].
2. The AdSS shall evaluate and review activity and performance during the Contract year prior to the NDMP's submission date and address the AdSS's plan for network development and related activity during the Contract year in which it was submitted in the NDMP.
3. The AdSS shall specify in the NDMP the process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.
4. The AdSS shall include in the NDMP a comprehensive description of elements identified in Attachment B and shall submit as

specified in Contract. In the submission, the AdSS shall include the following:

a. Attachment A, Network Attestation Statement.

b. Attachment B, Network Development and Management Plan Checklist, in Microsoft Word format.

c. Attachment F, the Centers of Excellence Checklist (COE), in Microsoft Word format.

d. The Centers of Excellence (COE).

5. The AdSS shall notify the Division in writing when there has been a material change that would affect network capacity and services as outlined in Contract and AdSS Operations Manual, Policy 439. The changes include changes in services, geographic service areas, and payments.

B. PERIODIC NETWORK REPORTING

1. The AdSS shall submit Attachment D, as specified in Contract for Provider changes Due to rates report.

2. The AdSS shall submit changes resulting in a material change to the Division as specified in ACOM Policy 439.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

Durable Medical Equipment (DME) Wheelchair Service Delivery Reporting;

Provider Network Development and Management Plan;

Provider/Network Changes Due to Rates Report Attachment D and E;

Centers of Excellence Attachment to Provider Network Development and Management Plan

416 PROVIDER INFORMATION

REVISION DATE: 1/3/2024

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12, 42 CFR 438.100, 42 CFR 438.102

PURPOSE

This Policy applies to the Division's Administrative Services Subcontractors. This Policy establishes guidelines for AdSS regarding provider information requirements.

DEFINITIONS

1. "Americans With Disabilities Act" or "ADA" means the Americans with Disabilities Act of 1990, as amended, that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in 42 U.S.C. 126 and 47 U.S.C. 5.

2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources.
    a. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.
    b. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and

conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

c. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Material Change to the Provider Network" means any change that affects, or can reasonably be foreseen to affect, the AdSS's ability to meet the performance and provider network standards as required in contract including, any change that would cause or is likely to cause more than 5% of the Members in a Geographic Service Area (GSA) to change the location where services are received or rendered.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.

5. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care.

a. A PCP may be:

i. A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17;

ii. A practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25;

iii. A certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15; or

iv. A naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

b. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

6. "Provider" means any person or entity that contracts with the Division, AHCCCS, or an AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.

6. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.
7. "Subcontractor" means:
    a. A provider of health care who agrees to furnish covered services to Members.
    b. A person, agency or organization with which the AdSS has contracted or delegated some of its management or administrative functions or responsibilities.
    c. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease of real property to obtain space, supplies equipment, or services provided under the Division agreement.
8. "Value-Based Purchasing" or "VBP" means a payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals and

measures in accordance with the VBP strategy selected for the contract.

a. VBP is a non-encounterable payment and does not reflect payment for a direct medical service to a member.

b. VBP payment typically occurs after the completion of the contract period but could include quarterly or semiannual payments if contract terms specify such payments in recognition of successful performance measurement.

POLICY

A. The AdSS shall develop, distribute, and maintain a provider manual. The AdSS shall ensure that each contracted provider is made aware of the provider manual available on the AdSS's website or, if requested, issued a hard copy of the provider manual. The AdSS shall distribute a provider manual to any individual or group that submits claim and encounter data.

B. The AdSS shall ensure that all providers, whether contracted or not, meet the applicable Division and AHCCCS requirements with regard to covered services and billing.

C. The AdSS shall ensure that, at a minimum, the AdSS's provider manual contains information on the following:

1. The ability of the Member’s Primary Care Physician (PCP) to treat behavioral health conditions within the scope of their practice.
2. Introduction to the AdSS that explains the AdSS's organization and administrative structure.
3. Provider responsibility and the AdSS's expectation of the provider.
4. Overview of the AdSS's Provider Services department and its function, including the expected response times for provider inquiries.
5. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services.
6. Appropriate and inappropriate use of the emergency department.
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

i. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations.

ii. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.

8. Description of dental services coverage and limitations.

9. Description of maternity and family planning services.

10. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.

11. Process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

12. Grievance and Appeal system process and procedures for providers and enrollees.

13. Billing and encounter submission information.

14. AdSS policies and procedures relevant to the providers that contain:
    a. Utilization management;
    b. Claims submission;
    c. Criteria for identifying provider locations that accommodate Members with physical or cognitive disabilities; and
    d. Primary Care Provider (PCP) assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.
15. Procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, that contains:
    a. Assigned Members' name,
    b. Assigned Members' date of birth,
    c. Assigned Members' AHCCCS ID,
    d. AHCCCS ID of the assigned PCP, and

e. Effective date of Member assignment to the PCP.

16. Policies relevant to providers including:

    a. Payment responsibilities as outlined in AdSS Operations Policy 432.

    b. Description of the Change of Contractor policies as outlined in AdSS Operations Policy 401.

    c. Nursing Facility and Alternative Home and Community Based Service (HCBS) Setting contract termination procedures as outlined in AdSS Operations Policy 421.

17. Reimbursement policies, including reimbursement for Members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

18. Cost sharing responsibility.

19. Explanation of remittance advice.

20. Criteria for the disclosure of Member health information.

21. Medical record standards.

22. Prior authorization and notification requirements, including a list of most frequently used services that require authorization, and

instructions on how to obtain a complete listing of services that require authorization.

23. Requirements for out-of-state placements for Members.
24. Claims medical review.
25. Concurrent review.
26. Coordination of care requirements, including designation of an Employment Coordinator as the statewide point of contact for the referral of Members requesting employment services from the Division.
27. Credentialing and re-credentialing activities.
28. Fraud, waste, and abuse as specified in AdSS Operations Policy 103.
29. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including prior authorization and limits specified in AdSS Medical Policy 310-V, the AdSS monitoring process for prescribers in AdSS Medical Policy 310-FF, and informed consent requirements in AdSS Medical Policy 320-Q.

30. The AHCCCS Drug List and the AHCCCS Behavioral Health Drug List information available in a machine readable file and format, and information on:
    a. How to access the drug lists electronically or by hard copy upon request, and
    b. How and when updates to these lists are communicated.
31. Division and AHCCCS appointment standards.
32. Requirements pertaining to duty to warn and duty to report as outlined in Division Medical Manual, Policy 960.
33. Information for behavioral health providers on their responsibilities for submitting to the Division demographic information according to the AHCCCS DUGless Portal Guide34. Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964 requirements, as applicable.
35. Process providers shall use to notify the AdSS and the Division when a provider changes address, contact information, or other demographic information.

36. Information on services available through the AHCCCS Provider Enrollment Portal, how to access the portal, and how to update provider registration data including current population groups sets served.
37. Eligibility verification.
38. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964 and information on how to access interpretation services to assist Members who speak a language other than English, including Sign Language, as specified in AdSS Operations Policy 405.
39. Peer review and the provider's ability to dispute the process.
40. Medication management services as specified in the AdSS contract with the Division.
41. Member's rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including the right to:
    a. Be treated with dignity and respect.

b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

c. Participate in treatment decisions regarding health care, including the right to refuse treatment.

d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

e. Request and receive a copy of the medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable state law.

f. Exercise rights and the exercise of those rights without adversely affecting service delivery to the Member.

42. That the AdSS has no policies that prevent the provider from advocating on behalf of the Member as specified in 42 CFR 438.102.

43. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

44. General and informed consent for treatment requirements.

45. Advance directives.
46. Transition of Members.
47. Encounter validation studies.
48. Incidents, accidents, and deaths reporting requirements as specified in AdSS Medical Manual 961.
49. Pre-petition screening, court ordered evaluations, and court ordered treatment.
50. Behavioral health assessment and service planning requirements:
    a. As specified in AMPM Policy 320-O;
    b. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650;
    c. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040;
    d. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P;

e. Partnership requirements with families and family-run organizations in the children and adult behavioral health system; and

f. Peer support and recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

51. Housing criteria for individuals determined to have SMI.
52. Seclusion, restraint, and emergency reporting requirements.
53. The SMI grievance and appeal process.
54. How providers assist Members in obtaining a Member Handbook and other new Member materials.
55. Outreach, engagement, re-engagement, and closure activities.
56. Requirements for grant funded services provided to Special Populations.
57. Behavioral health crisis intervention service requirements.
58. Partnership requirements with families and family-run organizations in the children and adult behavioral health system.

59. Training requirements.

60. The AdSS shall include guidance in the Provider Manual on which services are the responsibility of AdSS and which services are the responsibility of providers contracted with AdSS, and directions on how providers unsure of these responsibilities can obtain guidance.

D. REQUIRED NOTIFICATIONS

1. In addition to the updates required in this section, the AdSS shall require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, AdSS shall provide prior notification.

2. AdSS shall provide written or electronic communication to contracted providers in the following instances:

    a. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, AdSS shall provide written notice of the reason for declining any written request for inclusion in the network.

b. Material Changes - AdSS shall notify providers in advance of any Material Change to the Provider Network or business operations as specified in ACOM policy 439.

c. AdSS Policy and Procedure Changes – For any change in policy, process, or protocol, including prior authorization, retrospective review, or performance and network standards that affects or can reasonably be foreseen to affect the AdSS's ability to meet performance standards of AdSS contract with the Division, AdSS shall notify:

   i. The designated operations compliance officer to which AdSS is assigned, sixty calendar days before a proposed change, and

   ii. Affected provider, thirty calendar days before the proposed change.

d. AHCCCS Guidelines, Policy, and Manual Changes - AdSS shall notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals.

e. AdSS Provider Manual Changes - AdSS shall notify its providers when modifications are made to the provider manual.

f. Subcontract Updates

i. If a modification to the AHCCCS Minimum Subcontract Provisions are modified, AdSS shall issue a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts.

ii. AdSS shall amend the affected subcontracts on their regular renewal schedule or within six calendar months of the update, whichever comes first.

g. Termination of Contract – AdSS shall provide, or require its subcontractors to provide, written notice to hospitals and provider groups at least 90 calendar days prior to any contract termination, other than contracts between subcontractors and individual practitioners, without cause.

h. Disease and Chronic Care Management – AdSS shall disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

3. The Division shall distribute other communication to the AdSS upon request of AHCCCS. In these instances, AHCCCS shall provide prior notification.

417 APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING, AND REPORTING

REVISION DATE: 2/28/2024, 1/25/2023, 1/26/2022
REVIEW DATE: 10/10/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.206; 42 CFR 438.206(b)(4); 42 CFR 438.206(c)(1)((i)-(vi; ; 42 CFR 438.207(b); 42 CFR 457.1230 (a); A.R.S. § 8-512.01; ACOM 415; ACOM 417, ACOM Attachments A and B, ACOM 449

PURPOSE

This policy establishes Appointment accessibility and availability standards to ensure compliance with the Division's network sufficiency requirements.

This policy establishes a common process for the AdSS to monitor and report Provider Appointment accessibility and availability to the Division. These policy requirements do not apply to emergency conditions. This policy applies to the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "1800 Report" means an Arizona Health Care Cost Containment System (AHCCCS) generated document provided quarterly, that

identifies Primary Care Physicians (PCPs) with a panel of more than 1800 AHCCCS members.

2. "Appointment" means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or service Provider in Provider and service categories identified below.

3. "Network Development and Management Plan" or "NDMP" means a plan the AdSS develops and maintains to ensure the provision of covered services will occur as stated in the Contract. The Network Development and Management Plan (NDMP) shall specify the AdSS' process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.

4. "Provider" means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or

referring for those services, and is legally authorized to do so by the State.

5. "Urgent Care Appointment" means an Appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

A. APPOINTMENT STANDARDS

1. The AdSS shall require adherence to service accessibility standards and the contractual Appointment standards contained in 42 CFR 457.1230 (a) and 42 CFR 438.206.

2. The AdSS shall provide a comprehensive Provider network that provides access to all services covered under the Contract for all Members.

3. The AdSS shall cover contracted services through an out of network Provider until a network Provider is contracted if the

AdSS's network is unable to provide medically necessary services required under the Contract.

4. The AdSS shall use the results of Appointment standards, monitoring to validate it has an adequate network of Providers ensuring timely service coverage, and to reduce unnecessary emergency department utilization.

5. The AdSS shall have written policies and procedures about educating its Provider network regarding Appointment time requirements.

6. The AdSS shall:

   a. Develop a corrective action plan when Appointment standards are not met.

   b. Develop a corrective action plan in conjunction with the Provider when appropriate.

B. GENERAL APPOINTMENT STANDARDS

The AdSS shall require the following Appointment standards are met:

1. For primary care Provider Appointments:
    a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days of request, and
    b. Routine care Appointments scheduled within 21 calendar days of request.
2. For specialty physician Appointments, including dental specialists:
    a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days from the request, and
    b. Routine care Appointments scheduled within 45 calendar days of referral.
3. For dental Provider Appointments:
    a. Urgent Care Appointments scheduled as

expeditiously as the Member's health condition requires, but no later than three business days of request; and

b. Routine care Appointments scheduled within 45 calendar days of request.

4. For maternity care Provider Appointments:

Initial prenatal care Appointments for enrolled pregnant Members provided as follows:

a. First trimester, Appointments scheduled within 14 calendar days of request;

b. Second trimester, Appointments scheduled within seven calendar days of request;

c. Third trimester, Appointments scheduled within three business days of request; and

d. High-risk pregnancies, Appointments scheduled as expeditiously as the Member's health condition requires and no later than three

business days of identification of high risk by the AdSS or maternity care Provider, or immediately if an emergency exists.

C. PSYCHOTROPIC MEDICATION APPOINTMENT STANDARDS

The AdSS shall adhere to the following psychotropic medication Appointment standards:

1. Assess the urgency of the need immediately; and
2. Provide an Appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the Member:
   a. Does not run out of needed medications; or
   b. Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

D. GENERAL BEHAVIORAL HEALTH APPOINTMENT STANDARDS

The AdSS shall ensure the following general behavioral health Appointment standards are met:

1. For behavioral health Provider Appointments:

   Urgent need Appointments occur as expeditiously as the Member's health condition requires but no later than 24 hours from identification of need.

2. Initial assessment:

   Occur within seven calendar days after the initial referral or request for behavioral health services.

3. Initial Appointment:

   a. Occur within time frames indicated by clinical need.

   b. Occur no later than 23 calendar days after the

initial assessment for Members age 18 and older; and

c. Occur no later than 21 days after the initial assessment for Members under the age of 18 years old.

4. Subsequent behavioral health services:

Occur as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

E. BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR PERSONS IN LEGAL CUSTODY OF THE ARIZONA DEPARTMENT OF CHILD SAFETY (DCS) AND ADOPTED CHILDREN

1. The AdSS shall ensure the following Appointment standards are met:

a. Rapid response:

When a child enters out-of-home placement within

the time frame indicated by the behavioral health condition, but no later than 72 hours after notification by the Arizona Department of Child Safety (DCS) that a child has been or will be removed from their home;

b. Initial assessment:

Within seven calendar days after the initial referral or request for behavioral health services;

c. Initial Appointment:

Within time frames indicated by clinical need, but no later than 21 calendar days after the initial assessment; and

d. Subsequent behavioral health services:

Within the time frames according to the needs of the person, but no longer than 21 calendar days from the identification of need.

2. The AdSS shall require Appointment standards for Members

in the legal custody of the DCS and adopted children are adhered to in order to monitor Appointment accessibility and availability.

F. PROVIDER APPOINTMENT AVAILABILITY REVIEW

1. The AdSS shall conduct regular reviews of Providers to assess the availability of routine and urgent Appointments for primary care, specialist, dental, behavioral health Providers, and behavioral health Appointments for Members in the legal custody of DCS and adopted children.

2. The AdSS shall review the availability of routine and urgent Appointments for maternity care Providers relating to the first, second, and third trimesters, as well as high risk pregnancies.

3. The AdSS shall consider an Appointment available to be delivered through telehealth an available Appointment where clinically appropriate.

4. The AdSS shall conduct Provider Appointment availability reviews

as a method to ensure sufficient Provider network capacity.

5. The AdSS shall conduct Provider Appointment availability reviews for all Providers or a statistically relevant sample of Providers throughout the Contract year.

6. The AdSS shall only use one of these methods at a time for conducting reviews:
   a. Appointment schedule review that independently validates Appointment availability,
   b. Secret shopper phone calls that anonymously validate Appointment availability, or
   c. Other methods approved by the Division.

7. The AdSS shall supplement the monitoring efforts prescribed in (F)(1) through (F)(6) by targeting specific Providers identified through the following performance monitoring systems:
   a. The 1800 Report,
   b. Quality of care concerns,

c. Complaints,

d. Grievances, or

e. The credentialing process.

8. The AdSS shall address any plans to change its existing methodologies for Appointment availability reviews in its annual NDMP as specified in ACOM Attachment 415-B.

9. The AdSS shall submit to the Division a request for approval for any additional methodologies that outline details, including scope, selection criteria, and any tools used to collect the information prior to implementing the proposed method, as specified in the Contract.

G. TRANSPORTATION TIMELINESS REVIEW

1. The AdSS shall ensure that medically necessary, non-emergent transportation is provided so a Member arrives on time for an Appointment, but no sooner than one hour before the Appointment; or wait no more than one hour after the

conclusion of the treatment for transportation home.

2. The AdSS shall ensure the following AHCCCS performance target is met: 95% of all combined completed pickup and drop off trips in a quarter are completed in the time frame specified in section (G)(1) above.

3. The AdSS shall evaluate compliance with these standards on a quarterly basis for all subcontracted transportation vendors or brokers and require corrective action if standards are not met.

4. The AdSS shall track all scheduled trips that were not completed.

H. TRACKING AND REPORTING

1. The AdSS shall track Provider compliance with Appointment availability and transportation timeliness as specified in the Contract, the F3 Chart of Deliverables, and outlined below in sections (H)(2) through (H)(4).

2. The AdSS shall submit to the Division a cover letter with ACOM

Attachment 417-A including all of the following:

a. A description of the methods used to collect the information;

b. An explanation of whether the AdSS is surveying all Providers in their network or a sample.

c. A sample of the Provider network needs to include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level;

d. A summary of the findings and an explanation of trends in either a positive or negative direction;

e. An analysis of the potential causes for these findings and trends; and

f. A description of any interventions applied to areas of concern including any corrective actions taken.

3. The AdSS shall submit to the Division ACOM Attachment 417-B

for each line of business, with a cover letter for each submission including all of the following:

a. A summary of the findings including any identified positive or negative trends for timeliness, incomplete trips, and their reasons;

b. An analysis of the potential causes for these findings and trends; and

c. A description of any intervention applied to areas of concern including any corrective actions taken.

4. The AdSS shall provide additional corrective action steps for any reporting quarter where the average percentage of all completed trips for that quarter falls below the performance target of 95%.

5. The AdSS shall include a timeline with the corrective action steps in order to meet the performance target of 95% of trips being completed in the time frame specified in section (G)(1) above.

6. The AdSS shall, as a component of the NDMP, annually:

a. Conduct a review of its network sufficiency when there has been a significant decrease in Appointment availability performance over the previous year;

b. Compare its annual average performance to the previous Contract year's average performance for each standard, Provider type and Appointment type subcategory specified within this Policy under the sections for General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards; and

c. Conduct a review of the sufficiency of its Provider network for any standard that decreased by more than five percentage points.

SUPPLEMENTAL INFORMATION

1. For additional information on behavioral health services and behavioral health standards for persons in the legal custody of

the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. § 8-512.01, refer to AdSS Policy 449.

2. Refer to AdSS Policy 415 for additional requirements regarding the submission of the NDMP.

418 PROVIDER AND AFFILIATE ADVANCE AND LOAN REQUEST

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901
DELIVERABLES: Equity Distributions; Provider Advances and Loans

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It establishes guidelines for the provision of advances and loans by the AdSS to providers and affiliates (related parties), including another line of business or fund within the AdSS organization.

Definitions

A. Affiliate (Related Party) - A party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by a contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

B. Advance – Includes, but is not limited to, payment to a provider or affiliate by a contractor that is based on an estimate of Received but Unpaid Claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the contractor.

C. Affiliate (Related Party) Transactions - Transactions with a party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by the contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

D. Day - Calendar day unless otherwise specified.

E. Provider - Any person or entity that contracts with the AdSS for the provision of covered services to members consistent with A.R.S. § 36-2901, or any subcontractor of a provider delivering services consistent with A.R.S. § 36-2901.

Advances and Loans

A. Individual and Cumulative Provider Advances

The AdSS must submit a written request for approval to the Division for any individual or cumulative provider advances in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. All requests for prior

approval are to be submitted to the Division's Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

All requests for approval must be in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
    a. The provider(s) name(s) and AHCCCS Identification Number(s)
    b. The date the provider and AdSS initiated discussions relating to the need for the advance
    c. The systemic organizational causes resulting in the need for an advance
    d. The process that will be utilized to reconcile the funds against claims payments
    e. The anticipated timeline for the project
    f. The corrective action(s) that will be implemented to avoid future occurrences; and,
    g. The total advance amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.
2. A copy of the written communication that will serve as notification to the affected provider(s).
3. Upon completion of the advance(s), the Division may request that the AdSS make available within three working days a listing of the payments to be advanced, organized by provider TIN if multiple providers are affected, that includes the following:
    a. AHCCCS Member ID
    b. Date of Service
    c. Original AHCCCS Claim Number
    d. Date of payment
    e. Amount paid
    f. Amount advanced
    g. Balance Due to/from the provider.

B. Individual and Cumulative Provider Loans

The AdSS must submit written notification to the Division of any individual or cumulative provider loan equal to or in excess of $50,000 per provider TIN within a contract year. All requests for prior approval are to be submitted to Division's Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

1. All requests for approval must include:

   a. A detailed letter of explanation must be submitted that describes the:

      i. Provider(s) name(s) and AHCCCS Identification Number(s)

      ii. Date the provider and contractor initiated discussions relating to the need for the loan

      iii. Systemic organizational causes resulting in the need for a loan

      iv. Process that will be utilized to reconcile the funds against claims payments

      v. Anticipated timeline for the project

      vi. Corrective action(s) that will be implemented to avoid future occurrences

      vii. Total loan amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.

   b. A copy of the written communication that will serve as notification to the affected provider(s).

2. Upon completion of the loan(s), the Division may request that the AdSS make available within three working days a listing of the payment(s) loaned, organized by provider TIN if multiple providers are affected, that includes the following:

   a. AHCCCS Member ID

   b. Date of service

   c. Original AHCCCS Claim Number

   d. Date of payment

   e. Amount paid

   f. Amount loaned

g. Balance due to/from the provider

C. Routine/Scheduled Advances or Loans to Providers and Any Advances or Loans to Affiliates

Routine/scheduled advances or loans to providers as a result of contractual arrangements, or **any** advance or loans to an affiliate, must be submitted to the Division for prior approval. The request for approval must be submitted to the Division's Compliance Unit.

The Division may request additional information or periodic reconciliations related to these advances.

D. Routine/Scheduled Advances, Distributions, Loans, Loan Guarantees or Affiliates

The AdSS must submit a written request for approval to the Division for any advances, equity distributions, loans, loan guarantees, or investments in/to related parties or affiliates, including to another fund or line of business within its organization, within a contract year. Prior approval requests must be submitted 30 days prior to the anticipated date of distribution.

All approval requests must be submitted in the format of a detailed letter of explanation that describes the:

a. Related Party or Affiliate name

b. Amount

c. Type of request

d. Purpose or reason for request

e. Expected date of investment or distribution.

Division Responsibility and Authority

The Division reserves the right to evaluate and present all proposed advances, loans, loan guarantees, distributions, and investments, to the affected providers(s), related parties, or affiliates, as part of the approval and/or notification process. Communication will be at the timing and discretion of the Division.

The Division evaluates all advance and loan requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. A written determination will be sent to the AdSS by electronic mail contingent upon receipt of all required information from the AdSS.

421 CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE HOME AND COMMUNITY BASED SETTINGS

EFFECTIVE DATE: October 1,2019

REFERENCES: A.A.C. R9-28-101 et seq.; 42 CFR 483; AMPM Chapter 1200, Section 1230

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). This policy is limited to, and defines, the relationship between a Nursing Facility (NF) and/or an Alternative Home and Community Based Setting (AHCBS) and an AdSS following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. This policy delineates how the AdSS, NF, and AHCBS collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

Definitions

A. Add-On **-** Generally refers to contract standards that an AdSS may have with a NF to establish criteria for additional payment to the Class 1, 2, or 3 levels determined by the Universal Assessment Tool (UAT).

B. Alternative Home and Community Based Setting - Under the Home and Community Based Services (HCBS) program, members may receive certain services while they are living in an alternative HCBS setting. HCBS settings as defined in A.A.C. R9-28-101 et seq., and AMPM Chapter 1200, Section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH), Behavioral Health Residential Facilities, and Behavioral Health Supportive Homes.

C. Bed Hold Day **-** A 24 hour per day unit of service that is authorized by the Division Support Coordinator or the AdSS, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and/or therapeutic leave.

1. Short Term Hospitalization Leave – This service may be authorized for members residing in a Nursing Facility (NF), Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID) or Residential Treatment Center (RTC) that is licensed as a Behavioral Health Inpatient Facility when short-term hospitalization is medically necessary. The total number of days available for each member per year is limited to 12 days per contract year except as in #3 below.

2. Therapeutic Leave – If included in the member's care plan, this service may be authorized for members residing in an NF, ICF/IID or RTC that is licensed as a Behavioral Health Inpatient Facility due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as a part of discharge planning. The total number of therapeutic leave days available for each member per year is limited to nine days per contract year except as in #3 below.

3. Members under 21 years of age may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per year.

D. Nursing Facility (NF) - A health care facility that is licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Contracted NFs are those facilities that have a contract with an AdSS. Non-contracted NFs are those facilities that do not have a contract with an AdSS.

E. Subacute or Specialty Care - Generally refers to contract standards that an AdSS may have with a NF to establish criteria for paying a rate higher than the Class 1, 2 and 3 levels determined by the UAT.

F. Uniform Assessment Tool (UAT) - A standardized tool that is used by the AdSS to assess the acuity of NF residents and commonly used for HCBS residents residing in Assisted Living Centers (ALC) or Assisted Living Homes (ALH) settings. The use of the UAT is not intended to impact how the AdSS determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management). This tool is located in Chapter 1600 of the AHCCCS Medical Policy Manual.

Policy

A. Member/Resident Options When an NF or AHCBS Contract is Terminated

Affected members residing in an NF and/or HCBS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available AdSS that is contracted with the facility, or move to a setting that is contracted with their current AdSS.

A meeting between the AdSS, NF and/or HCBS and the Division will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

The AdSS in collaboration with the NF and/or AHCBS and the Division must develop a member/representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The AdSS must receive approval of their member/representative communication plan from the Division.

The plan must be submitted to the Division within five business days of the termination decision. All member communications must be consistent with guidelines found in the AdSS Operations Manual, Policy 404.

B. Reimbursement

1. Nursing Facilities

The AdSS must reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, the AdSS must reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or the AdSS's previously contracted rates. Should AHCCCS reduce its fee schedule, the AdSS must reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

If the AdSS had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the AdSS must apply those rates. If AHCCCS adjusts its fee schedule, the AdSS will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Home and Community Based Settings

The AdSS must reimburse the Alternative Home and Community Based Setting at the previously contracted rate. If AHCCCS adjusts its HCBS Fee Schedule rates, the AdSS will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

C. Quality of Care

If an AdSS or other entity, such as Arizona Department of Health Services (ADHS) Licensure, the Division, or AHCCCS identifies instances where the overall quality of care delivered by an NF or AHCBS places residents in immediate jeopardy, the AdSS will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or AHCBS.

In some cases, ADHS, the Division, or AHCCCS may require that the AdSS find new placements for members. In such cases, the AdSS must work with the members/representative to identify an appropriate placement that meets the needs of the member. The Division may require the AdSS to increase monitoring of facilities identified as having health or safety issues until the Division is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or HCBS, the AdSS must notify the Division. In these instances, the AdSS should review the financial, health and safety status prior to placing a member in a placement owned by the same entity. If an AdSS identifies a member specific quality of care concern, the AdSS must identify the concern to the NF or ARS for resolution. The AdSS must also report to external entities and to the Division as required by Division Medical Policy Manual Chapter 900.

D. Admissions/Discharges/Readmissions

1. NFs or AHCBSs are not required to accept new admissions of members who are not enrolled with the AdSS.

2. NFs are required to otherwise follow admission, readmission, transfer, and discharge rights, as specified in 42 CFR 438.12.

3. The AdSS may authorize bed hold days up to the allowed limit as specified in 9 A.A.C. 28.

423 FINANCIAL RESPONSIBILITY FOR COURT ORDERED TREATMENT FOR DUI/DOMESTIC VIOLENCE OR OTHER CRIMINAL OFFENSES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 28-1301, 28-1381, 28-1382, or 28-1383; A.R.S. § 36-2021 et seq.
DELIVERABLES: Monthly Outpatient Court Ordered Treatment

This Policy applies to Division's Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide clarification regarding the financial responsibility for the provision of specific mental health treatment/care when such treatment is ordered because of a judicial ruling.

Definitions

Court-Ordered Alcohol Treatment - Detoxification services or treatment provided according to A.R.S. Title 36, Chapter 18, Article 2.

DUI Client -An individual who is ordered by the court to receive DUI screening, DUI education, or DUI treatment as a result of an arrest or conviction for a violation of A.R.S. §§28-1381,§28-1382, or §28-1383.

DUI Education - A program in which a person participates in at least sixteen hours of classroom instruction relating to alcohol or other drugs.

DUI Screening - A preliminary interview and assessment of an offender to determine if the offender requires alcohol or other drug education or treatment. (A.R.S. §28-1301)

DUI Services - DUI Screening, DUI education, or DUI treatment provided to a member eligible for the Division.

DUI Treatment - A program consisting of at least twenty hours of participation in a group setting dealing with alcohol or other drugs in addition to the sixteen hours of education. (A.R.S. §28-1301)

Driving Under The Influence (DUI)

The AdSS is responsible for covering and reimbursing for services when the services are Division or AHCCCS covered, medically necessary services described in Statute, Rule, Contract or Policy. A court order is not necessarily a substitute for the AdSS obligation to determine the amount, duration and scope of medically necessary services. The AdSS should not assume that a court or administrative agency ordering DUI screening, education or treatment services is aware of the scope of the Division or AHCCCS covered services or of how medical necessity is defined for purposes of the Medicaid program. Nevertheless, the AdSS may take into consideration, the medical information and factual findings of the court or administrative agency in making the AdSS determination of medical necessity.

When a DUI screening, education or treatment is ordered by the court for a person who has been charged for driving under the influence pursuant to A.R.S. §36-2027, the cost

of the screening, education and/or treatment is the responsibility of the county, city, town, or charter city whose court ordered the screening, education and/or

treatment. See A.R.S. §36-2027 (E). The county, city or town is a source of third party liability for any court ordered evaluation and/or treatment services that are also Division or AHCCCS covered services. Upon receipt of the claim, the AdSS should deny the claim and return it to the provider with directions to bill the responsible county, city or town.

Domestic Violence Offender Treatment

When a person is convicted of a misdemeanor domestic violence offense, pursuant to A.R.S. §13-3601, the sentencing judge must order the person to complete a domestic violence offender treatment program that is provided by a facility approved by the Department of Health Services or a probation department. Pursuant to A.R.S. §13-3601.01. A person who is ordered to complete a domestic violence offender treatment program must pay the cost of the program.

Although a judge may determine that court ordered domestic violence offender treatment (including educational classes to meet the requirements of the court order) is the financial responsibility of the offender under A.R.S. §13-3601.01, a member eligible for the Division cannot be considered a legally responsible third party with respect to themselves. As a result, it is the Division's expectation that the AdSS responsible for the provision of behavioral health services will provide domestic violence offender treatment when the service is deemed medically necessary. The member is not a source of first or third party liability as defined in A.A.C. R9-22-1001 when required prior authorization is obtained and/or the service is provided by an in-network provider. The AdSS must provide medically necessary services and ensure that the member's medical record includes documentation to justify the medical necessity for the services rendered.

Court Ordered Treatment For Persons Accused Of Other Crimes

Pursuant to A.R.S §36-2027, a court may order evaluation and treatment at an approved treatment facility of a person who is brought before the court and charged with a crime if:

A. It appears the person is an alcoholic, and

B. Such person chooses the evaluation and treatment procedures. The court cannot order the person to undergo treatment and evaluation for more than 30 days.

The cost of evaluation and treatment of an indigent patient treated pursuant to a court order under A.R.S. §36-2027 is the responsibility of the county, city, town or charter city whose court issued the order for evaluation.

When evaluation or treatment is ordered pursuant to this statute, the county, city, town or charter city whose court issued the order for evaluation is responsible for the cost of services to the extent ordered by the court. To the extent those services are

also Division covered services and the AdSS receives a claim for the services, the AdSS may direct the provider to bill the appropriate county, city, town or charter city.

Financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of court-ordered evaluation is outlined in this Policy Manual, Policy 437.

424 VERIFICATION OF RECEIPT OF PAID SERVICES

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 433.116, 42 CFR 455.20 and 232; AHCCCS Contractor Operations Manual, Policy 424-Attachment A; Section F3, Contractor Chart of Deliverables

DELIVERABLES: AHCCCS Required Survey Results; Verification of Receipt of Paid Services

Purpose

This policy applies to the Division's Administrative Services Subcontractors (AdSS). AdSS are responsible for verifying member receipt of paid services according to federal and contractual requirements, to identify potential service/claim fraud. The AdSS are expected to perform surveys as required in this policy through member contact and to report the results of these surveys to the Division in accordance with the timeframes specified in Section F3, Contractor Chart of Deliverables.

General Requirements

A. The AdSS must perform, at a minimum, quarterly surveys to determine member receipt of paid services.

B. A Quarterly Verification of Services Survey Report, is due as specified in Section F3, Chart of Deliverables. The AdSS will submit this information, using the format in AHCCCS Contractor Operations Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report.

Sampling

A. The sampling must be from claims with Dates of Services (DOS) from the reporting quarter and not more than 45 days from date of payment pursuant to 42 CFR 455.232 and 433.116(e). For example, the July 15th report would be for paid claims with DOS for January through March. Surveys can be performed at any point after claims have been paid.

B. Members who are surveyed must be eligible for the Division and enrolled with the AdSS during the period under review.

C. The sampling must consist of claims that resulted in payment.

D. The sampling must be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility).

E. The sample size must be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an AdSS with less than 2,000 members must be 50 claims (the minimum sample size refers to completed surveys).

Methodology

A. The audit can be performed by mail, telephonically, or in person. Concurrent review will be allowed; however, if used it must be recorded and tied back to a

successfully adjudicated claim.

B. Survey language should be in an easily understood language, including the description of services (e.g., x-ray, surgery, blood tests, counseling) when validating the receipt of paid services.

C. Individual survey results indicating that paid services may not have been received must be referred to the AdSSs fraud and abuse department for review and to the AHCCCS Office of the Inspector General (AHCCCS-OIG) department.

Reporting

A. The AdSS must submit a report that includes the total number of surveys sent out, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS-OIG for further review (AHCCCS Operations Policy Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report).

B. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the AdSS's corporate compliance program and, as a result, any referrals to AHCCCS-OIG and analysis and interventions where appropriate.

425 SOCIAL NETWORKING

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10 and 438.104; 45 CFR 164.500 et seq; ACOM Policy 425 - Attachment A, Social Networking Attestation Statement; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Communications Administrator (Name and Contact Information); Social Networking Administrator (Name and Contact Information); Social Networking Applications Listing with URLs; Social Networking Attestation

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS may choose whether to engage in Social Networking activities; should they choose to participate this policy and its requirements apply. This policy establishes the requirements for the Division's AdSS regarding social networking activities.

Definitions

A. Broadcast - Video, Audio, or text transmitted through Social Networking Applications, via internet, cellular or wireless network for display on any device (e.g., comments, podcasts, blogs).

B. Friends/Followers - Persons who choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

C. Marketing - Any communication from a AdSS to a member of the Division who is not enrolled with that AdSS that can reasonably be interpreted as intended to influence enrollment in that particular AdSS, or to not enroll in, or to disenroll from, another AdSS.

D. Social Networking Activities - The use of Social Networking Applications, the development of AdSS-specific Social Networking Application sites/ pages, and Broadcast activities.

E. Social Networking Application - Web based services/platforms (excluding the AdSS's State mandated website content, member portal, and provider portal) for online collaboration that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services – collectively also referred to as social media (e.g., Facebook).

F. Tags/Tagging - Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

G. Username - An identifying pseudonym associating the author to messages or content generated.

Social Networking Activities

A. AdSS must participate in Social Networking Activities to support learning and engagement.

B. All Social Networking material must comply with the requirements of this Policy, as well as the requirements for member information as outlined in AdSS Operations Manual, Policy 404. Any changes or amendments to previously approved member informational materials used in Social Networking Activities must be resubmitted to the Division in accordance with AdSS Operations Manual, Policy 404.

C. The AdSS is responsible for reviewing and continuous monitoring of its Social Networking Activities to ensure adherence to Division policy including, but not limited to, marketing restrictions, member information guidelines, and adherence to HIPAA Privacy Rules and provisions regarding safeguarding of Protected Health Information (PHI) [42 CFR 438.104, 42 CFR 438.10, 45 CFR Part 164, Subpart E].

D. The Division reserves the right to monitor the activities of the AdSS, including but not limited to, AdSS's oversight of its Social Networking Activities, to ensure ongoing compliance with this policy. The Division may perform audits as deemed necessary.

Social Networking Requirements

The AdSS must adhere to the following requirements when engaging in Social Networking Activities. The AdSS must:

A. Address programs and services of the Division program in support of the mission and delivery of services.

B. Safeguard member privacy information from unauthorized use or disclosure, which includes the security of Protected Health Information (PHI) and adherence to all HIPAA Privacy Rules, Division policies and contractual requirements.

C. Designate a Social Networking Administrator who is responsible for policy development, implementation and oversight of all social networking activities.

D. Use all available security features to prevent fraud and unauthorized access.

E. Ensure all connections must be initiated by the external user and not the AdSS.

F. Ensure all Social Networking Application sites and Broadcasts are clear, direct, professional, accurate, and presented in a well-organized manner. The AdSS should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.

G. Comply with copyright and intellectual property law and reference or cite sources appropriately.

H. Have a presence on Social Networking Application sites and must include an Avatar and/or a Username that clearly indicates what company is being represented.

I. Develop an internal company policy, based on the requirements of this policy, for the use of Social Networking and Broadcasts with regard to the Division's lines of

business. The policy must include a statement of purpose/general information explaining how the AdSS uses Social Networking and Broadcasting and how the AdSS continuously monitors Social Networking Activities. The AdSS must ensure applicable staff receives instruction and/or training on the Division and AdSS social networking policies before using social networking applications and broadcasts on behalf of the AdSS.

Social Networking Restrictions

The AdSS must adhere to the following restrictions regarding Social Networking Activities:

A. Social networking applications and broadcasts for the purposes of Marketing are prohibited.

B. The AdSS must not solicit feedback from members via social networking applications or broadcasts.

C. External user-generated content (comments/posts) is not permitted unless the AdSS has an intermediary review process in place in which the AdSS ensures all postings are appropriate and are in compliance with this policy.

D. The AdSS must not post information, photos, videos, links/URLs or other items online that reflect negatively on any individual(s), members of the Division enrolled with the AdSS, AHCCCS, the Division, or the state.

E. The AdSS is prohibited from tagging photographic or video content and must promptly remove all tags placed by others upon discovery unless written consent by those tagged has been obtained.

F. The AdSS must not identify members by name, or post, share, or publish information, including a member photo, that may lead to the identification of a member unless written consent has been obtained by the member.

G. The AdSS is prohibited from posting ads, whether targeted or general, on Social Networking Application platforms.

H. No affiliate/referral links or banners are permitted. This includes links to other non- Medicaid lines of business that the AdSS or a corporate affiliate is engaged in. When using any Social Networking Application which may automatically generate such linkage, recommendation, or endorsement on side bars or pop-ups (e.g., Facebook), the AdSS's Social Networking Application page must contain a disclaimer message prominently displayed in the area under the AdSS's control stating that such **items, resources, and companies are NOT endorsed by the AdSS, the Division, or AHCCCS.**

I. The use of the Department of Economic Security logo, AHCCCS logo, or State of Arizona seal is prohibited.

J. The use of materials that are inaccurate, misleading, or that otherwise make misrepresentations are prohibited.

AdSS Reporting Requirements

The AdSS must submit ACOM 425 Attachment A-Social Networking Attestation Statement, as specified in Section F3, Contractor Chart of Deliverables. Attachment A must include a listing of all Social Networking Applications used in the contract year with associated URLs.

426 CHILDREN'S REHABILITATIVE SERVICES APPLICATION, DESIGNATION AND COVERAGE

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 36-2912; A.A.C. R9-22- 1301, A.A.C. R9-22-1303, A.A.C. R9-22-1305

DELIVERABLES: CRS Members With Completed Treatment

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). This Policy defines the processes used to accept and process applications for a Children's Rehabilitative Services (CRS) designation, and delineates the responsibility for coverage and payment of CRS conditions as well as other services that are the responsibility of the AdSS.

Definitions

A. Active Treatment - A current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22- 1301).

B. CRS Application - A submitted form with additional documentation required by the AHCCCS Division of Member Services (DMS) in order to make a determination whether an AHCCCS member is medically eligible for a CRS Designation.

C. CRS Condition - Pursuant to A.R.S. § 36-2912, those covered conditions that are medically disabling or potentially disabling and which qualify for CRS medical eligibility as specified in A.A.C. R9-22-1303.

D. Redetermination - A decision made by the AHCCCS DMS regarding whether a member continues to meet the requirements in A.A.C. R9-22-1305.

Policy

The AdSS must provide covered services to members under the age of 21 who have been confirmed to have a CRS condition requiring active treatment, as described in A.A.C. R9-22-1303. Members with a CRS qualifying condition will receive a CRS designation as determined by the Division of Member Services (DMS). AHCCCS may request, at any time, that the AdSS submit medical documentation to assist with review of a current CRS designation. DMS is responsible for processing and responding to requests for CRS designations and will accept and process an application in accordance with this Policy.

A. Application

1. Form Requirements – A CRS application must be submitted to DMS for a medical eligibility determination described in A.A.C. R9-22 Article 13. A copy of the required CRS application form and instructions are available on the AHCCCS website.

    a. The completed Application for AHCCCS CRS Designation may be faxed, mailed, or delivered in person to DMS as indicated on the AHCCCS website.

b. Upon submitting the completed CRS application to AHCCCS DMS, the AdSS must:

i. Notify in writing the member or his/her parent/guardian/ designated representative that an application for a CRS designation has been submitted on the member's behalf.

ii. Inform the member or his/her parent/guardian/designated representative that the member will be referred to a specialist for an evaluation of the CRS condition.

c. If a CRS application is submitted to AHCCCS by a provider acting on the member's behalf, the AdSS must work with the provider to ensure the AdSS is made aware of the application submission. Once the AdSS is made aware a provider has submitted an application, notification must be sent in accordance with b. above, and

d. The following documentation is required with submission of the application:

i. Documentation from a specialist who diagnosed the member, stating the member's diagnosis and the need for active treatment

ii. Diagnostic testing results that support the medical diagnosis.

2. Processing

a. DMS will verify Title XIX/XXI enrollment.

b. If further information is needed in order to make a determination of medical eligibility, DMS will contact the appropriate parties to request the information.

3. Determination and Notification

a. For members meeting medical eligibility criteria, DMS will identify the member with a CRS designation, effective on the same date as the determination, including those members who may be hospitalized at the time.

b. When a determination of CRS medical eligibility is made, DMS will notify the following parties:

i. Member/guardian/designated representative

ii. The entity who submitted the application (if authorized)

iii. The AdSS.

c. For members not meeting medical eligibility criteria, DMS will notify the member/guardian/designated representative and the AdSS of the decision.

The member's right to appeal the determination of medical eligibility, and the process for doing so, will be described in the DMS member notfication.

d. It is the responsibility of the AdSS to ensure that the information provided by DMS is made available to the appropriate areas and staff within its organization who may need the information.

B. Members Turning 21

At least 90 days prior to a member with a CRS designation turning 21 years of age, the AdSS must notify the member that his/her CRS designation ends upon his/her 21st birthday. The AdSS must ensure specialty services related to the member's CRS condition(s) are completed, as clinically appropriate, prior to the member's 21st birthday. The AdSS must continue to ensure appropriate service delivery and care coordination is provided, regardless of the member's CRS designation ending.

C. AdSS Responsibilities for CRS Services

The member may elect to use his/her private insurance network (providers) or Medicare providers to obtain health care services, including those for treatment of the CRS condition(s). AdSS responsibilities for payment of services for treatment of the CRS condition(s), when a member uses private insurance or Medicare, are further outlined in AdSS Operations Manual, Policies 201 and 434.

D. Termination of the CRS Designation

DMS may end a member's CRS designation for one of the following reasons:

1. The member loses Title XIX/XXI enrollment
2. The member no longer meets the medical eligibility criteria for CRS
3. The member has completed treatment for the CRS condition(s)
4. The Member turns 21 years of age. Refer to Section B of this Policy.

E. Request for Removal of the CRS Designation

In response to a member/guardian/designated representative's request for removing a CRS designation, DMS will send a CRS Designation Removal Form to the member/guardian/ designated representative for signature. Upon receipt of the signed form, DMS will end date the CRS designation.

F. Monitoring of the CRS Designation

Continued review of the CRS designation must be determined by verifying active treatment status of the CRS condition as described in A.A.C. R9-22-1305 and as follows:

1. AdSS Notification

   a. The AdSS is responsible for notifying AHCCCS of members under the age of 21 with a CRS designation who are no longer requiring active treatment for the CRS qualifying condition(s), including medical records indicating treatment has been completed,

   b. The AdSS must transmit to AHCCCS the members with Completed Treatment Report, for any member with a CRS designation who has completed treatment, and

   c. The above-referenced report must be sent as specified in Contract.

2. AHCCCS Notification

   a. If DMS determines that a CRS member is no longer medically eligible for CRS, DMS will end date the CRS designation in the member's record, and

   b. DMS will notify the member/guardian/designated representative that the member's CRS designation is inactive with AHCCCS.

431 COPAYMENT

EFFECTIVE DATE: October 1, 2019

Members eligible for the Division of Developmental Disabilities and the ALTCS Program must not be billed copayments for any medical service, including prescriptions. Members are exempt from mandatory and optional copayments.

433 MEMBER IDENTIFICATION CARDS

REVISION DATE: 5/10/2023, 10/1/2021, 12/02/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 433;

PURPOSE

This policy establishes requirements regarding the development, approval, and distribution of Member Identification Cards (ID Cards) and replacement ID Cards. This policy applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS) when members present for Medicaid services.

DEFINITIONS

1. "834 Enrollment Transaction File" means a nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly enrolled members and enrollment changes for existing members.

POLICY

A. PROGRAMMING REQUIREMENTS

1. The AdSS shall identify members requiring an ID Card as a result of the 834 Enrollment Transaction File. ID Cards shall be produced and distributed as follows:
    a. To new members within 12 business days from the business day following the Division providing the 834 Enrollment Transaction File to the AdSS, or
    b. Within five business days of the request for member replacement cards.
2. The AdSS may provide an option for the member to access the ID Card digitally in addition to providing the physical card.
3. The AdSSs shall monitor the timeliness standards in this policy for the ID Cards it issues directly.
4. The AdSS shall provide members with new ID Cards at least 14 calendar days prior to a new version going into effect.
5. The AdSS shall issue a combined Medicare Arizona Long Term Care System (ALTCS) ID Card when serving members dually enrolled in Medicare and the Division. The format for the combined ID Cards shall:

a. Meet the Centers for Medicare and Medicaid Services (CMS) requirements for ID Cards and be approved AHCCCS.

b. Meet the minimum formatting requirements identified in ACOM Policy 433 Attachment A as applying to ID Cards for members dually enrolled.

c. Adopt additional formatting features included in this policy or prescribed by CMS for the requirement of an ID Number, if the formatting does not conflict with this policy's minimum requirements.

B. FORMAT OF MEMBER IDENTIFICATION CARDS (ID CARDS)

1. The AdSS shall ensure ID Cards meet the format standards outlined in this policy or as specified in ACOM Policy 433 Attachment A. The following formatting standards apply:

   a. The front of the ID card shall include:

      i. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version.

ii. AHCCCS Logo in the approved color or black and white version no smaller than 1" long by .333" inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The AdSS must not edit or alter the approved logo, except as noted above.

iii. Arizona Health Care Cost Containment System in Arial font no smaller than 11 points.

iv. The following information in Arial font no smaller than 8 points:

1) Member's name
2) AHCCCS ID number
3) AdSS name
4) AdSS telephone number
5) Division telephone number
6) TTY/TDY telephone number for members who are deaf or hard of hearing
7) Statewide crisis phone number

8) The nurse triage telephone number.

b. The back of the ID card shall include:

i. In Arial font no smaller than 7 points:

1) The following text: "Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify health plan benefits, visit:

UnitedHealthcare Plan – www.uhc.com

Mercy Care Plan – www.mercycareaz.org

DDD Tribal Health Program (THP) –

DDD Customer Service 1-844-770-9500 ext. 7

2) The following text in the card's mailing to the member if a card holder is not used:: "To help protect your identity and prevent fraud, AHCCCS is adding pictures to its online verification tool that providers use to verify

your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details."

2. The Division may include additional information on the ID card or card holder identified as appropriate, subject to the approval requirements of this policy.
3. The Division shall include the most recent version of the AHCCCS Notice of Privacy Practices (NPP) with any new ID Card mailing.

C. APPROVAL OF MEMBER IDENTIFICATION CARDS, AND OTHER COMPLIANCE REQUIREMENTS

1. The AdSS shall submit the ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items to the Division for prior approval..

2. The AdSS shall submit ID Cards requiring Division approval, as specified in Contract.
3. The AdSS shall obtain prior approval from the Division if more than one version of an ID Card is issued to members.
4. The AdSS shall ensure the card holder and any letters or information mailed to the member with the ID Card complies with requirements as specified in AdSS Operations Manual, Policy 404.
5. The AdSS shall obtain approval prior to implementation of a subcontract to print or distribute member identification cards and identify the subcontractor in the Annual Subcontractor Assignment and Evaluation Report as outlined in the Division Operations Manual, Policy 438.

434 COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2923; A.A.C. R9-22-711, R9-22-1001 et seq, R9-22-1003; 42 U.S.C.1396a(a)(25)(A); 42 CFR 433.135 et seq, 42 CFR 433.136; Deficit Reduction Act of 2005 (Public Law 109-171), Section F3, Contractor Chart of Deliverables.

DELIVERABLES: Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Purpose

Federal law 42 U.S.C.1396a(a)(25)(A) requires Medicaid to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid members. The purpose of this policy is to delineate the AdSS's requirements for Coordination of Benefit (COB) activities and Third Party Liability (TPL) recoveries.

Definitions

A. COB - The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

B. Copayment – A monetary amount that a member pays directly to a provider at the time a covered service is rendered (A.A.C. R9-22-711).

C. Cost Avoidance - To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C.R9-22 -1001 et seq.

D. Post-Payment Recovery - Subsequent to payment of a service by a contractor, efforts by that contractor, to retrieve payment from a liable third-party. Pay and Chase is one type of post-payment recovery.

E. Third Party - An individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan [42 CFR 433.136].

F. TPL - The legal obligation of third parties (e.g., certain individuals, entities. insurers or programs) to pay part or all of the expenditures or medical assistance furnished under a Medicaid state plan.

Policy

A. The AdSS is the payor of last resort unless specifically prohibited by applicable state or federal law. This means AdSS must be used as a source of payment for covered services only after all other sources of payment have been exhausted. The AdSS must take reasonable measures to identify potentially legally liable third-party sources. The AdSS is responsible for making third party payer information available through the AdSS's verification systems for use. Third party payor information may

also be obtained through DDD Systems. The AdSS is responsible for communicating TPL responsibilities to subcontractors per A.A.C. R9-22-1003.

B. The AdSS must coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et seq., so that costs for services otherwise payable by the AdSS are cost avoided or recovered from a liable third party.

C. AdSS is not the payor of last resort when the following entities are the third party:

1. Indian Health Services (IHS/638), contract health
2. Title IV-E
3. Arizona Early Intervention Program (AZEIP)
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 U.S.C. 300ff et seq.
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G

The two methods used for COB are Cost Avoidance and Post-Payment Recovery. The AdSS must use these methods as described in A.A.C. R9-22-1001 et seq., federal and state law, and DDD policy.

Cost Avoidance

The AdSS must cost avoid a claim if it has determined the probable existence of a liable party at the time the claim is filed. Determining liability takes place when the AdSS receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member.

Post-Payment Recovery

Pay and Chase – The AdSS must pay the full amount of the claim according to the AdSS service rate or specified contracted rate and then seek reimbursement from any third party if the claim is for any of the following:

A. Prenatal care for pregnant women, including services that are part of a global OB package

B. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program

C. Services covered by TPL that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Retroactive Recoveries Involving Commercial Insurance Payor Sources

Tagging – For a period of two years from the date of service, the AdSS must engage in retroactive recovery efforts for claims paid to verify if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the AdSS will seek recovery from the commercial insurance. The AdSS is prohibited from recouping payments from providers or requiring the involvement of providers in any way, unless the provider was paid in full from both the AdSS and the commercial insurance.

The AdSS has two years from the date of service to recover payments for a particular claim, or to identify (tag) claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when the AdSS has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment prior to the end of the AdSS' two-year recovery period. The AdSS must identify tagged claims in a monthly claims match-off file submitted to DDD as outlined in the AHCCCS Technical Interface Guidelines (TIG).

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

Encounter Adjustments Flagging – Although all encounters related to the AdSS' retroactive recovery efforts outlined above must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the AdSS is prohibited from requesting adjustments from, or adjusting related payments to, providers.

Instead, the AdSS must submit an external replacement file (via an AHCCCS approved vendor using a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project.

In order to submit an external replacement file, the AdSS must contact the Division Encounter Unit at the completion of the recovery project for a list of approved vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Encounters will not be adjusted when recoveries occur as a result of AHCCCS' efforts. AHCCCS will instead flag all encounters that are impacted by retroactive commercial insurance recoveries and will develop and maintain a database to store recovery payments.

Using the data from the replacement file submitted by the AdSS, and the database used to store AHCCCS' recoveries, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments when appropriate.

Other Third-Party Liability Recoveries

The AdSS must identify the existence of other potentially liable third parties through a variety of methods, including referrals and data mining related to the following:

A. Motor vehicle cases

B. Other casualty cases

C. Tortfeasors

D. Restitution recoveries

E. Workers' compensation cases

AdSS Discovery and Reporting of a Liable Third-Party

Reporting Requirements (Involving Commercial Insurance Payor Sources)

If the ADSS discovers the probable existence of a liable third party that is not known to AHCCCS/ Division, or identifies any change in coverage, the AdSS must report the information via the TPL Leads File or the TPL Referral Web Portal as specified in Section F3, Contractor Chart of Deliverables.

Reporting Requirements (Referrals and Data Mining)

Upon the identification of a potentially liable third party via referrals or data mining as described above, the AdSS must report the potentially liable third parties to AHCCCS' TPL contractor for determination of a mass tort case, total plan case, or joint case. AHCCCS' TPL contractor will refer total plan cases to the AdSS to be processed in accordance with AHCCCS, state, and federal laws and policies.

The AdSS must report total plan case settlement information to the Division, using Attachment A, the AHCCCS-approved casualty recovery Total Plan Case Settlement Notification Form, within 10 business days from the settlement date or in a monthly file approved by the Division.

Reporting Cost Avoidance and Recovery Activity

The AdSS must submit quarterly updates regarding cost avoidance/recovery activity as specified in Section F3, Contractor Chart of Deliverables.

435 TELEPHONE PERFORMANCE STANDARDS AND REPORTING

REVISION DATE: 03/22/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 435; Attachment A (Worksheets A and B)

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes AdSS standards and reporting requirements regarding the AdSS's performance when handling Member and provider telephone calls. This policy does not include performance requirements for Crisis Services Response.

DEFINITIONS

1. "Average Speed of Answer (ASOA) means the average online wait time in seconds that the Member/provider waits from the moment the call is connected in the AdSS's phone switch until the call is picked up by a AdSS's representative or Interactive Voice Recognition System (IVR).
2. "Daily First Contact Call Resolution Rate (DFCCR)" means the number of calls received in a 24-hour period for which no

follow-up communication or internal phone transfer is needed, divided by the total number of calls received in the 24-hour period.

3. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
4. "Monthly Average Abandonment Rate (MAAR)" means this is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.
5. "Monthly Average Service Level (MASL)" means the total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).
6. "Monthly First Contact Call Resolution Rate (MFCCR)" means the sum of the DFCCRs divided by the number of business days in the reporting period.

POLICY

A. TELEPHONE PERFORMANCE STANDARDS

The AdSS shall adhere to the following Telephone Performance Standards for Member and provider calls monthly:

1. The ASOA shall be 45 seconds or less.
2. The MAAR shall be 5% or less.
3. The MFCCR shall be 70% or better.
4. The MASL shall be 75% or better.

B. TELEPHONE PERFORMANCE MEASURE REPORTS

1. The AdSS shall track performance based on standards noted above and report performance results monthly to the DDD OIFA Data Validation Specialist, including both AHCCCS worksheets within Attachment A:
   a. Worksheet A, Telephone Performance Measures Template to document the ASOA, MAAR, MFCCR, and MASL as described in this Policy.
   b. Worksheet B, Centralized Telephone Line Down Time Template to report:

i. Down time for AdSS centralized telephone lines,

ii. Dates of the occurrences; and

iii. Length of time they were out of service.

2. The AdSS in their report shall:

   a. Cover their performance during the previous twelve months;

   b. Submit as specified in Section F3, Contractor Chart of Deliverables; and

   c. Separately document performance for calls of the following types:

      i. Member Calls

      ii. Provider Calls.

3. The AdSS shall address non-compliance with any standard on this deliverable for any given month, by including in the report steps the AdSS plans to take to reduce the noncompliant performance.

436 NETWORK STANDARDS

REVISION DATES: 3/27/2024, 4/26/2023, 12/22/2021

REVIEW DATE: 9/12/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 32-1201 et seq 32-1901 et seq, 36-401 et seq, 36-421 et seq,; A.A.C. R9-10, R9-10-801 et seq, R9-22-101, R9-33-101 et seq; 42 § C.F.R. 438.206(b)(1); ACOM 415; ACOM 436; ACOM 438; AdSS Contract

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes Network Standards and the oversight and monitoring Network Standards for the AdSS.

DEFINITIONS

1. "Adult Developmental Home" or "ADH" means an Alternative Home and Community Based Service (HCBS) Setting for adults (18 or older) with Developmental Disabilities (DD) that is licensed by the Department of Economic Security (DES) to provide room, board, supervision and coordination of habilitation

and treatment for up to three residents as specified in A.R.S. § 36-551.

2. "Assisted Living Center" or "ALC" means an assisted living facility that provides resident rooms or residential units to eleven or more residents as specified in A.R.S. § 36-401.
3. "Assisted Living Facility" or "ALF" means a residential care institution that provides supervisory care services, personal care services, or directed care services on a continuing basis in compliance with Arizona Department of Health Services (ADHS) licensing criteria as specified in 9 A.A.C. 10, Article 8.
4. "Assisted Living Home" or "ALH" means an ALTCS approved alternative home and community based services (HCBS) setting that provides room and board, supervision, and coordination of necessary services to 10 or fewer residents.
5. "Attachment A" means, for the purpose of this policy, the ACOM Policy 436 Attachment A - Minimum Network Requirements Verifications Template document that specifies the Network

Standards in which the Division and the AdSS are required to meet.

6. "Behavioral Health Outpatient and Integrated Clinic, Adult" means a class of health care institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are age 18 and above.
7. "Behavioral Health Outpatient and Integrated Clinic, Pediatric" means a class of healthcare institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are under the age of 18.
8. "Behavioral Health Residential Facility" or "BHRF" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
    a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

9. "Cardiologist, Adult" means a Medical Doctor (MD) who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system for patients aged 18 and above.
10. "Cardiologist, Pediatric" means a Medical Doctor (MD) who specializes in the study or treatment of heart diseases and heart abnormalities for patients under the age of 18.
11. "Crisis Stabilization Facility" means an inpatient facility or outpatient treatment center licensed as specified in 9 A.A.C. 10 that provides crisis intervention services (stabilization).
12. "Dentist, Pediatric" means a medical professional regulated by the State Board of Dental Examiners and operating as specified in A.R.S. § 32-1201 for patients under the age of 18.
13. "District or Service District" means a section of Maricopa or Pima County defined by zip code for purposes of establishing and measuring minimum Network Standards for Developmentally

Disabled (DD) Group Homes and Assisted Living Centers, and Assisted Living Homes..

14. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
15. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record, as specified in 9 A.A.C. 22, Article 1 and 9 A.A.C. 28, Article 1.
16. "Group Home" means a community residential setting for not more than six individuals with intellectual/developmental disabilities, that provides room and board and daily rehabilitation and other assessed medically necessary services and supports to meet the needs of each individual as specified in A.R.S. § 36-551.

17. "Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:
    a. Health care institution as specified in A.R.S. § 36-401;
    b. Residential care institution as specified in A.R.S. § 36-401;
    c. Community residential setting as specified in A.R.S. § 36-551; or
    d. Behavioral health facility as specified in 9 A.A.C. 20, Articles 1,4,5, and 6.
18. "Hospital" means a class of healthcare institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient as specified in A.A.C. Title 9, Chapter 10, Article 1 and A.R.S. Title 36, Chapter 4, Articles 1, 2, and 3.

19. "Member" means the same as "client" as defined in A.R.S. § 36-551.
20. "Multi-Specialty Interdisciplinary Clinic" or "MSIC" means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
21. "Network" means physicians, health care Providers, suppliers and hospitals that contract with an AdSS to give care to Members.
22. "Network Standards" means, as defined in ACOM 436, the requirements the Division and AdSS must meet and monitor to ensure that all covered services are available and accessible to Members.
23. "Nursing Facility" means, as defined in 42 § U.S.C. 1936r(a):
    a. An institution or a distinct part of an institution that:
        i. Is primarily engaged in providing to residents:
            a) Skilled nursing care and related services for residents who require medical or nursing care;

b) Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals; or

c) On a regular basis, health-related care, and services to individuals who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

ii. Is not primarily for the care and treatment of mental diseases;

iii. Has in effect a transfer agreement. meeting the requirements of 42 § U.S.C. 1861(l), with one or more hospitals having agreements in effect under 42 § U.S.C. 1866.

b. Any facility that is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of a Nursing Facility outlined in this section.

24. "Obstetrician/Gynecologist" or "OB/GYN" means a healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs, or who possesses special knowledge, skills, and professional capability in the medical and surgical care of the female reproductive system and associated disorders.
25. "Pharmacy" means a facility regulated by the State Board of Pharmacy and operating under A.R.S. § 32-1901.
26. "Primary Care Provider (PCP), Adult" means a person who is responsible for the management of the health care of Members who are over 21 years of age. A PCP may be a:
    a. Person licensed as an allopathic or osteopathic physician;
    b. Practitioner defined as a licensed physician assistant; or
    c. Certified nurse practitioner.
27. "Primary Care Provider (PCP), Pediatric" means a person who is responsible for the management of health care of Members who are under 21 years of age. A PCP may be a:
    a. Person licensed as an allopathic or osteopathic physician,

b. Practitioner defined as a licensed physician assistant, or

c. Certified nurse practitioner

28. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.

29. "Provider Affiliation Transmission" or "PAT" means a data file which provides details of the Providers within the AdSS's Network and is used to measure compliance with Network adequacy requirements.

POLICY

A. GENERAL NETWORK STANDARDS REQUIREMENTS

1. The AdSS shall develop and maintain a Provider Network that is sufficient to provide all covered services to Members eligible for the Division.

2. Unless otherwise noted, the AdSS shall assess its Network against its entire membership for the purposes of complying with Network Standards.

3. If established Network Standards cannot be met, the AdSS shall provide an explanation in the Network Development and Management Plan (NDMP).

B. STATEWIDE TIME AND DISTANCE NETWORK STANDARDS

1. For each county in the AdSS' assigned service area, the AdSS shall have a Network in place to meet the time and distance standards specified in this policy.
2. If the AdSS delegates Network activities, the AdSS shall ensure subcontractor compliance with applicable Network Standards.
3. For the purposes of this policy, the AdSS shall use its Network of the following Provider types and specialties in the table below to calculate compliance with this policy's time and distance standards.

PROVIDER CATEGORY	REQUIRED PROVIDER/SPECIALTY TYPE(S)
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	77 or IC
Behavioral Health Residential Facility (BHRF)	B8
Cardiologist, Adult	08 or 31 with a Specialty Code of

	062 or 927
Cardiologist, Pediatric	08 or 31 with a Specialty Code of 062, 151, or 927
Crisis Stabilization Facility	02, 71, B5, B6, B7, or 77 and ICs that are authorized to provide behavioral health observation/stabilization in accordance with A.A.C. 9-10-1012.
Dentist, Pediatric	07 with a Specialty Code of 800 or 804, C2 Federally Qualified Health Centers (FQHCs) identified by AHCCCS
Hospitals	02 or C4
Nursing Facilities	22
Obstetrician/Gynecologist (OB/GYN)	08, 19, 31, or CN with a Specialty Code of 089, 090, 091, 095, 181, or 219
Pharmacy	03 or 05
Primary Care Provider (PCP), Adult	08 or 31 with a Specialty Code of 050, 055, 060, 089, or 091 or
	19, CN with a Specialty Code of 084, 095, or 097 or
	18 with a Specialty Code of 798
Primary Care Provider (PCP), Pediatrics	08 or 31 with a Specialty Code of 050 , 150, or 176

	or
	19, CN with a Specialty Code of 084 , 087, or 097 or
	18 with a Specialty Code of 798

4. The AdSS shall use the methodology outlined in the table below to calculate its compliance with the following time and distance standards.

PROVIDER CATEGORY	APPLIES TO	MEMBER POPULATION	COUNTY	STANDARD (90% of membership does not need to travel more than)
Behavioral Health Outpatient and Integrated Clinic, Adult*	All Except CHP	18 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	60 miles from their residence
Behavioral Health Outpatient and Integrated	All*	under 18 years	Maricopa, Pima	15 minutes or 10 miles from their residence

Clinic, Pediatric*			All Others	60 miles from their residence
Behavioral Health Residential Facility (BHRF)	All	All	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	(Report in Network Plan, Refer to ACOM Policy 415-Attachment B)
Cardiologist, Adult*	All except CHP	21 years or older	Maricopa, Pima	30 minutes or 20 miles from their residence
			All Others	75 minutes or 60 miles from their residence
Cardiologist, Pediatric*	All	Under 21 years	Maricopa, Pima	60 minutes or 45 miles from their residence
			All Others	110 minutes or 100 miles from their residence
Crisis	ACC-RBHA	All	Maricopa,	15 minutes

Stabilization Facility	Only		Pima	or 10 miles from their residence
			All Others	45 miles from their residence
Dentist, Pediatric	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Hospitals	All	All	Maricopa, Pima	45 minutes or 40 miles from their residence
			All Others	95 minutes or 85 miles from their residence
Nursing Facilities	ALTCS E/PD Only	Living in "Own Home"	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	95 minutes or 85 miles from their residence

Obstetrician /Gynecologist (OB/GYN)	All	15 to 45 years old	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	90 minutes or 75 miles from their residence
Pharmacy	All	All	Maricopa, Pima	12 minutes or 8 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Adult*	All Except CHP	21 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Pediatrics*	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes

				or 30 miles from their residence

5. The AdSS shall ensure Provider types marked with an asterisk are:
   a. Eligible for a telehealth standard modification; and
   b. Require 80 percent of a county's membership to meet time and distance standards in any county where telehealth services are available for the Provider category.
6. Multi-Specialty Interdisciplinary Clinic (MSIC) Network Standards
   a. The AdSS shall contract with all MSICs in the assigned Geographic Service Area (GSAs);
   b. Any MSICs which have provided services to the AdSS's Members; and
   c. The AdSS shall identify all contracted MSICs in Attachment A, including any MSIC Providers it has contracted with and the AHCCCS approval date.

C. NETWORK STANDARD REQUEST FOR EXCEPTION PROCESS

1. When the AdSS has exhausted its efforts to meet any Network Standard specified in this policy, the AdSS shall submit a request for an exception to the Network Standards to the Division.
2. The AdSS shall include the following required elements when submitting the request to the Division for an exception to the Network Standards as specified in the AdSS contract:
    a. The county or counties covered under the exception request;
    b. The Provider types covered under the exception request;
    c. A geospatial analysis showing the current Member access to the Provider types and counties covered under the exception request;
    d. An explanation describing why the AdSS cannot meet the established Network Standard requirements;
    e. An explanation of the efforts to contract with non-contracted providers that may bring the AdSS into compliance with the Network Standard, including a

discussion of the appropriateness of the rates offered to non-contracted Providers;

f. The AdSS's proposal for monitoring and ensuring Member access to services offered by Provider types under the exception request; and

g. The AdSS's plan for periodic review to identify when conditions in the exception area have changed, and the exception is no longer needed.

D. NETWORK OVERSIGHT REQUIREMENTS

1. Minimum Network Standards Reporting Requirements

   a. The AdSS shall, in accordance with contract specifications, submit to the Division a completed Attachment A to report compliance with the applicable Network Standards in this policy.

   b. The AdSS shall utilize the Attachment A tab that details the minimum Network requirements in each county to report the following minimum Network requirements:

i. Minimum contracts within a specific city or group of cities;

ii. Contracts within specified distances to specific cities;

iii. Minimum contracts within a county; and

iv. In certain instances, contracts in locations outside of a county's boundary, if applicable.

c. The AdSS shall submit a separate report for each line of business for each county in the assigned service area.

d. For purposes of calculating and reporting Network Standards data, the AdSS shall:

i. Use its enrollment and its Network as of the last day of the reporting period (March 31 and September 30);

ii. Report the percentages in Attachment A, 'Time and Distance' tab rounded to the nearest tenth of a percent; and

iii. Report 'N/R' (None Reported) for each time and distance standard, instead of a percentage, where

there are no Members meeting the population criteria in the county.

iv. Report in Attachment A, 'Time and Distance' tab, whether or not telehealth services are available in each county reported for each Provider type eligible for a telehealth standard modification by the AdSS,by adding a 'Y' or 'N' in the "Telehealth Available (Y/N)" row underneath the Provider type; and

v. Consider in its dental Network any contracted FQHC identified annually by AHCCCS as providing dental services.

e. The AdSS shall analyze compliance with the minimum Network Standards based upon the Provider Network reported through the Contractor Provider Affiliation Transmission (PAT) and EVV data as required in AdSS Medical Policy 542. With the submission of Attachment A,

the AdSS shall include a summary including, at a minimum, the following:

i. The AdSS strategies and efforts to address any areas of non-compliances;

ii. A summary of exceptions granted to the Network Standards specified in this policy; and

iii. The results of the AdSS's monitoring of Member access to the services governed under the exception.

c. As specified in the AdSS contract with the Division, the AdSS shall submit a completed Attachment A including a summary analysis of any areas of non-compliance with Network Standards specified in this policy, including strategies and efforts to address areas of non-compliance.

2. Network Plan Requirements

a. The AdSS shall take steps to ensure Network Standards are maintained.

i. If established Network Standards cannot be met, the AdSS shall identify gaps and address short and

long-term interventions in the Network Development and Management Plan (NDMP) as specified in AdSS Operations Policy 415.

ii. When an exception has been granted, the AdSS shall address the sufficiency of Member access to the area, and assess the continued need for the exception.

b. The AdSS shall report the Network gaps to the Division and short and long-term interventions to address the gaps, in its NDMP as specified in AdSS Operations Policy 415.

437 FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT-ORDERED EVALUATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-501.33, 36-520 et seq, 36-533 et seq, 36-545.04, 36-545.06, 36-545.07

This Policy applies to the Division's Administrative Services Subcontractors. The purpose of this Policy is to provide clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation (COE).

Definitions

A. Court-Ordered Evaluation - The proceedings and related services described in A.R.S. § 36-520 et seq (Title 36, Chapter 5, Article 4).

B. Court-Ordered Treatment - The proceedings and related services described in A.R.S. § 36-533 et seq (Title 36, Chapter 5, Article 5).

C. Medically Necessary Behavioral Health Services - Those behavioral health services necessary, in the judgment of a qualified medical practitioner, to treat an existing behavioral health condition or illness and/or to prevent the patient from potentially harming themselves or others.

D. Prepetition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services pursuant to A.R.S. §36-501.33.

Policy

AdSS subject to this Policy are responsible for providing medically necessary, covered behavioral health services to members including services provided pursuant to court order under A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5). As a matter of state law (A.R.S. §36-545.04), the cost of services provided as part of a legal proceeding under A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4) (Court-Ordered Evaluation) is the financial responsibility of the county in which the individual resided or was found (i.e., the county of origin).

Under A.R.S. §36-545.06, the cost of pre-petition screening and court-ordered evaluation is a county responsibility unless the county has an agreement with AHCCCS under A.R.S. § 36-545.07 to provide those services for the county.

Absent such an agreement between the state and the county, the AdSS is responsible for medically necessary, covered behavioral health services other than services associated

with the pre-petition screening and court-ordered evaluation. Services are NOT considered the county's responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis.
- A petition for court ordered treatment is filed with the court.
- The member is released following the evaluation.

The issue of voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. Furthermore, the refusal of a member eligible for Title XIX to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Services that are Medicaid covered for a Medicaid enrolled member that are separate from the COE services (such as case management) can continue to be paid with Title XIX funding during the COE time period.

The AdSS must accept and process timely claim submissions for medically necessary services for all members eligible for Title XIX receiving COE services in an inpatient setting for time periods that are not the county responsibility.

Fiscal responsibility for physical health services provided during the COE process remains with the AdSS with which the member is enrolled for the provision of physical health services, and is not the responsibility of the County of origin.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS EVALUATION

REVISION DATE: 3/27/2024, 7/26/2023, 2/16/2022

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901, ACOM 438 Attachments A and B, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, and CMS document SMDL #09-001.

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines and requirements for the AdSS entering into Administrative Services Subcontracts or Management Services Agreement (MSA) and monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and Corrective Action Plans (CAPs). Unless otherwise stated, requirements outlined in this policy for Administrative Services Subcontractors also apply to MSA.

DEFINITIONS

1. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the contract with the Division, including:
    a. Claims processing, including pharmacy claims;
    b. Pharmacy Benefit manager (PBM);
    c. Dental Benefit Manager;
    d. Credentialing, including those for only primary source verification;
    e. Medicaid Accountable Organization (ACO); and
    f. Service Level Agreements with the Division or Subsidiary of a corporate parent owner.
2. "Attachment A" means the Attachment A of the Administrative Services Subcontract Checklist. It is the AHCCCS deliverable template.
3. "Change in Organizational Structure" means any of the following:
    a. Merger
    b. Acquisition

c. Reorganization

d. Change in Articles of Incorporation

e. Joint Venture

f. Change in Ownership

g. Change of Management Services Agreement (MSA) Subcontractor

h. Other applicable changes that may cause:

i. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

ii. Changes in critical Member information, including the website, Provider handbook and Member ID card

iii. A change in legal entity name.

4. "Corrective Action Plan" or "CAP" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are

generally used to improve performance of the Contractor or its Providers, to enhance Quality Management or Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

5. "Management Service Agreement" or "MSA" means a type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
6. "Medicaid Accountable Care Organization" or "ACO" means an entity that enters into a Value-Based Purchasing (VBP) arrangement with a Contractor which:
    a. Improves the health care delivery system by increasing the quality of care while reducing costs.
    b. Enters into VBP contracts with Provider groups or networks of groups.
    c. Coordinates Provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM),

combined with quality incentives to ensure both quality outcomes and cost containment.

d. Supports Providers participating in APMs by providing services such as data analytics, technical assistance, Provider education, and Provider recruitment.

e. Operates as an intermediary between the Contractor and Providers, but not as a Provider of direct services to Members.

f. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS.

7. "Member" means the same as "client" as defined in A.R.S. § 36-551.

8. "Provider" means any person or entity that contracts with the AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a Provider delivering services pursuant to

A.R.S. § 36-2901. Providers are not Administrative Services Subcontractors.

9. "Quality of Care" or "QOC" means an expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.
10. "Request for Proposal" or "RFP" means a document prepared by AHCCCS that describes the services required and that instructs a prospective Offeror how to prepare a response.
11. "Subcontractor" means:
    a. A provider of health care who agrees to furnish covered services to Members.
    b. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

c. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease or leases of real property to obtain space, supplies equipment or services provided under the AHCCCS agreement.

POLICY

A. APPROVAL OF SUBCONTRACTS

1. The AdSS shall submit all Management Services Agreements (MSA) and Administrative Services Subcontracts to the Division for prior approval as noted below and as specified in the AdSS contract with the Division, 60 days before the effective date of the subcontract.

   a. The AdSS shall submit an unredacted copy of the proposed Subcontract to the Division with AHCCCS Contractor Operations Policy Manual (ACOM) Policy 438 Attachment A, Administrative Services Subcontract Checklist.

b. The local Chief Executive Officer (CEO) shall retain the authority to direct and prioritize all work performed through a delegated contract.

c. The AdSS shall require that subcontractors meet any performance standards applicable to the delegated services as mandated by the Division and AHCCCS.

   i. The AdSS shall notify a change in Organizational Structure of Administrative Services Subcontractor to the Division.

   ii. If a complete Attachment A submission is required, the AdSS shall follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this policy.

d. The AdSS shall notify and obtain prior approval from the Division of a Change in Organizational Structure of an Administrative Services Subcontractor.

   i. If the Change in Organizational Structure is related to the AdSS MSA, the AdSS shall submit the

proposed change for prior approval as outlined in AdSS Operations Policy Manual, Policy 317.

B. MONITORING AND REPORTING

1. The AdSS shall adhere to all requirements for any contractual relationship and delegation as listed in 42 CFR 438.230.
2. The AdSS shall monitor its subcontractor's performance on an ongoing basis and complete a formal review of the subcontractors at least annually.
3. In the formal review, the AdSS shall conduct a review of delegated duties, responsibilities, and financial position of the subcontractors.
4. If at any time during the period of the Administrative Service Subcontract, the subcontractor is found to be in non-compliance, the AdSS shall notify the Division within 30 days of discovery with the following information:
    a. The subcontractor's name
    b. Delegated duties and responsibilities

c. Identified areas of non-compliance and whether the non-compliance affects Member services or causes a quality of care concern

d. The scope and estimated impact of the non-compliance upon Members

e. The known or estimated length of time that the subcontractor has been in non-compliance

f. The subcontractor's CAP or strategies to bring the subcontractor into compliance

g. Sanction actions that may be taken because of the non-compliance

5. The AdSS shall review and respond to any follow-up questions for more information related to an open CAP requested by the Division.

6. The AdSS shall communicate the results of a CAP with the Division upon closure of the CAP.

C. EVALUATION REPORT

1. The AdSS shall submit a completed Administrative Services Subcontractor Evaluation Report annually, using ACOM Policy 438, Attachment B, Administrative Services Subcontractor Evaluation Report Template.
2. The AdSS shall ensure that the Administrative Services Subcontractor Evaluation Report includes the following:
    a. The name of the subcontractor;
    b. The delegated duties and responsibilities;
    c. The date of the most recent formal review of the duties, responsibilities, and financial position, as appropriate, of the subcontractor;
    d. A comprehensive summary of the evaluation of the operational and financial, as appropriate, performance of the subcontractor, including the type of review performed;
    e. The next scheduled formal review date;
    f. All identified areas of deficiency that:
        i. Affect Member services; or

ii. Cause a quality of care concern; and

g. CAP Information, including:

i. Date reported to the Division;

ii. A detailed description of the reason(s) the Subcontractor was placed on a CAP;

iii. A description of the steps taken by the Subcontractor to address the CAP; and

iv. The current status and expected completion time of the CAP.

D. ADDITIONAL REQUIREMENTS

1. Before entering into an Administrative Services Subcontract, the AdSS shall evaluate the prospective subcontractor's ability to perform the delegated duties.
2. The AdSS shall ensure that all Administrative Services Subcontracts reference and comply with the Minimum Subcontract Provisions available on the AHCCCS website.

3. In the event of a modification to Division Policy, guidelines, and manuals, the AdSS shall issue a notification of the change to its affected subcontractors of any affected subcontracts.
4. The AdSS shall amend the affected Administrative Services Subcontracts on the regular renewal schedule or within six calendar months of the update, whichever comes first.
5. In the event of a modification to Minimum Subcontract Provisions, the AdSS shall issue a notification and amend Administrative Services Subcontracts.
6. The AdSS shall ensure that all Administrative Services Subcontracts reference and comply with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436, and State Director Letter (SMDL) 09-001.
7. AdSS shall disclose to the Division the identity of any excluded person.

8. The AdSS shall ensure that all Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the Division Contract.
9. The AdSS shall maintain a fully executed original or electronic copy of all Administrative Services Subcontracts and make them accessible to the Division within five business days of the request by the Division according to contract requirements.
10. The AdSS shall ensure that all Member communications furnished by the AdSS include the Division's name and comply with Member notification requirements as outlined in AdSS Operations Manual, Policy 404.
11. If the AdSS terminates a subcontract, the AdSS shall ensure compliance with all aspects of the Division contract notwithstanding the subcontractor termination, including availability of and access to all covered services and provision of covered services to Members within the required timeliness standards.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

1. Administrative Services Subcontracts
2. Administrative Services Subcontractor Evaluation Report
3. Administrative Services Subcontractor Non-Compliance Reporting
4. Corporate Cost Allocation Plans and Adjustment in Management Fees

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-22-101; 42 CFR 438.10(f)(4) and 207; Contract

DELIVERABLES: Material Change to Business Operations; Material Change to Provider Network

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes requirements for the AdSS regarding the identification and assessment of material changes to the AdSS's provider network and business operations and the approval process for such changes.

Definitions

A. Administrative Services Subcontracts - An agreement that delegates any of the requirements of the contract with Division, including:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification
3. Management Service Agreements
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSSs.

B. Delegated Agreement - A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the AdSS pursuant to this contract.

C. Geographical Service Area (GSA) - An area designated by the Division within which an AdSS of record provides, directly or through subcontract, covered health care services to a member enrolled with that AdSS of record, as defined in A.A.C. R9-22-101.

D. Management Services Agreement (MSA) - A type of subcontract with an entity in which the owner of the AdSS delegates some or all of the comprehensive management and administrative services necessary for the operation of the AdSS.

E. Material Change to Business Operations - Any change in overall operations that affects, or can reasonably be foreseen to affect, the AdSS's ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific geographic region. Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Additional changes may include the addition of, or change in:

- Pharmacy Benefits Manager (PMB)
- Dental Benefit Manager
- Transportation vendor
- Claims processing system
- System changes and upgrades
- Member ID card vendor
- Call center system
- Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment
- MSA
- Any administrative services subcontract.

F. Material Change to the Provider Network - Any change in composition of, or payments to, an AdSS's provider network, that affects, or can reasonably be foreseen to affect, the AdSS's adequacy of capacity and services necessary to meet the performance and/or provider network standards as required in contract. Changes to provider network may include, but not limited to:

- Any change that would cause, or is likely to cause, more than 5% of the members in a geographic region to change the location where services are received or rendered
- Any change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.

G. Provider Group - Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

H. Unexpected Material Change to the Provider Network or Business Operations – A material change that was not anticipated by the AdSS.

Examples of unexpected changes to the provider network include providers giving less than 30 days' notice to the AdSS that they would no longer serve Medicaid members, or the AdSS's failure to reach an agreement with a provider on a contract renewal less than 30 days before the previous contract expires. An example of an unexpected Material Change to Business Operations includes the unexpected closure of a subcontractor.

The AdSS must have efficient and effective business operations and provider networks to ensure that performance and provider network standards are met to support a member's

needs, as well as the needs of the membership as a whole. The AdSS must develop a process to determine when changes to business operations or to the provider network constitute a material change.

Division or AHCCCS-initiated changes, such as changes in reimbursement methodologies (e.g. APR- DRG) or changes to reference tables impacting claims payment, and industry-initiated changes, such as CPT/Diagnosis code changes, are excluded from these policy requirements.

Identifying A Provider Network and/or Business Operations Material Change

A. The AdSS is responsible for evaluating all business operational and provider network changes, including unexpected changes, to determine if the change is a material change.

B. For changes impacting members and/or providers regarding the provider network and/or business operations, the AdSS must:

   1. Establish criteria and/or methodology for determining the impact of the change to members and providers.

   2. Evaluate the impact of the change to its membership and provider network, by geographic region as specified by the Division and as a whole, using the established criteria and/or methodology.

   3. Determine, based on the evaluation results, whether the change meets the definition of a material change as outlined in this policy, and determine whether it complies with contract and policy requirements.

   4. Maintain documentation of evaluation of all provider network and business operations changes.

C. The Division may request and review documentation of established methodology, criteria, and evaluation results, for all provider network and business operations changes, even for those changes that the AdSS determines do not constitute a material change.

D. For all changes that have a member impact, the AdSS must provide member notification as outlined in Policy 404 in the AdSS Operations Policy Manual.

E. Implementation must be planned to ensure continuity of care to members.

F. A Material Change to Business Operations may also constitute a Material Change to the Provider Network.

G. The Division reserves the right to identify an operations or network change as a material change.

Administrative Services Subcontractor Reporting Requirements

A. The AdSS must request, in writing, prior approval of a Material Change to the

Provider Network or business operations in accordance with this policy. A request for approval must include a detailed description of the proposed change and all requirements outlined above and summarized in AHCCCS Operations Manual Policy 439 Attachment A, the Provider Network/Business Operations Material Change Plan Checklist, as adopted by the Division.

B. For all material changes, the AdSS must include an accessibility analysis of the services impacted by the provider change:

1. For services the member must travel to receive, the AdSS must provide the average time and distance that members in the impacted areas must travel for the service before and after the change.

2. For services provided in the member's home, the AdSS must address the geographic coverage and sufficiency of providers in the impacted area before and after the change.

3. For transportation services, the AdSS must address the availability of vehicles dedicated to the AdSS line of business in the impacted area before and after the changes.

C. The AdSS must request prior approval, in writing, of a material change that involves major system changes and upgrades to the AdSS's information system that, at a minimum, affects claims processing, payment, or other major business component, or system changes that impact member or provider interactions with the AdSS. A request for approval must include a system change plan that includes a timeline and milestones, and outlines adequate testing to be completed before implementation.

D. A material change in the provider network and/or business operations requires a 30-day advance written notice from the AdSS to members and providers [42 CFR 438.10(g)(4).

E. If there is an unexpected Material Change to the Provider Network and/or to business operations, the AdSS must submit written notification to the Division no later than one business day of the AdSS becoming aware of the unexpected change. Notification must be submitted as specified in contract. The notification must include a detailed description of the change, address why it was unexpected, and include all of the requirements identified in AHCCCS Operations Manual Policy 439 Attachment A. If the AdSS is unable to provide some or all of the Attachment A requirements in its initial notification, the remaining requirements must be provided to the Division with one week of initial notification. The AdSS must also identify its plan for notifying members or providers of the unexpected change..

F. For any provider termination, when appropriate, the AdSS must make a good faith effort to give written notice to enrollees within 15 days after receipt or issuance of a provider termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

G. The Division will review and respond to AdSS requests for approval within 30 days of the submission. Incomplete submissions will not be approved and additional

information may be requested. The approval process will be expedited upon request for emergency situations.

H. The AdSS may be required to provide periodic updates on the status of the change or implementation.

I. The AdSS may be required to conduct meetings with providers and/or members to provide general information or technical assistance, or to address issues related to changes to business operations, changes in policy, reimbursement matters, prior authorizations, and other matters as identified or requested by the Division.

440 MANAGED CARE EXPIRATION OR TERMINATION OF CONTRACT

EFFECTIVE DATES: October 1, 2019

This Policy applies to Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to set forth requirements and responsibilities when the Contract between the Division and AdSS expires (contract expiration) or is terminated by either the Division or the AdSS (contract termination).

Definitions

A. Contract - A written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29.

B. Contract Expiration - The ending of the Contract pursuant to its terms without any action by a party to the agreement.

C. Contract Termination - The cancellation of the Contract, in whole or part (e.g. by GSA), as a result of an action taken by the Division or the AdSS.

D. Incurred but Not Reported (IBNR) - The liability for services rendered for which claims have not been received.

Policy

The AdSS is required to adhere to certain notification requirements and comply with specific responsibilities as outlined in Contract and this Policy in the event of Contract Expiration or Contract Termination. Upon determination of Contract Expiration/Termination, the Division will provide notice to the AdSS outlining the AdSS operational and reporting requirements for the Contract Expiration/Termination transition period as described below.

In either instance, Contract Expiration or Contract Termination, the AdSS is required to develop and submit a Plan to the Division for prior approval as described in the *General AdSS Responsibillities* section of this Policy. The Plan must clearly present the AdSS process for ensuring compliance with all contractual responsibilities through the transition period, regardless of whether a Contract expires or is terminated. AdSS are responsible to assist the Division in the transition of members.

AdSS Non-Renewal - General Notifications

A. If the AdSS elects not to renew the Contract, the AdSS provides the Division with at least a 180 day advance written notice prior to the Non-Renewal of the current Contract.

B. After receipt of the AdSS notification of intent not to renew, the Division will issue written notice to the AdSS specifying:

1. The effective date of termination

2. The AdSS operational and reporting requirements.

3. Timelines for submission of deliverables.

The Division Non-Renewal – General Notification

If the Division elects not to renew the Contract, the Division will provide written notice prior to the Non-renewal of the current Contract.

Contract Terminations by Contract Termination by the Division - General Notification

A. The Division may initiate termination actions for reasons, including but not limited to:

1. An AdSS notification of or refusal to sign a contract amendment.
2. Substantial failure to provide medically necessary services that the AdSS is required to provide under law or the terms of its contract to its enrolled members.
3. Failure to meet the Division Financial Viability Standards.
4. Material deficiencies in the AdSS provider network.
5. Failure to meet quality of care and quality management requirements.
6. Failure to comply with contract provisions or applicable state and federal laws or regulations.
7. For convenience, as stipulated in Contract.

B. In the event the Division initiates a Termination for Convenience action, pursuant to the Contract Terms and Conditions, the Division will provide written notice of the termination at least 90 days before the effective date of the termination. The notice will include the effective date of the termination and the AdSS operational and reporting requirements.

C. In the event the Division initiates a termination action of a Contract for failure to meet the requirements of Federal Law or the Contract the Division will provide the AdSS with notice of intent to terminate, the reason for termination and hearing rights [42 CFR 438.710].

1. In the event AdSS does not contest the intent to terminate the Contract, the Division will notify the AdSS in writing of:
   a. The effective date of termination
   b. The AdSS operational and reporting requirements
   c. Timelines for submission of deliverables.
2. In the event the AdSS files a request for a hearing to challenge the intent to terminate and the termination is upheld through the Administrative Hearing process, the Division will notify the AdSS in writing of:
   a. The effective date of termination

b. The AdSS operational and reporting requirements

c. Timelines for submission of deliverables.

D. The Division will provide AHCCCS with written notice no later than 30 days after the date of Contract termination, in accordance with 42 CFR 438.724.

General AdSS Responsibilities

For Contract expirations and terminations, the AdSS must adhere to the following:

A. Produce reports timely and perform all responsibilities through the dates specified in the Division notification.

B. Comply with all terms of the Contract including, but not limited to, the provision of all management and administrative services throughout the transition.

C. Maintain adequate staffing to perform all required functions as specified in Contract.

D. Designate an individual as Contract Transition Coordinator who must ensure the continuance of AdSS performance, operations, and member transitions through a time determined by AdSS, and provide this individual's contact information with submission of the Contract Expiration or Termination Plan.

E. Participate in any meetings, workgroups, trainings, or other activities scheduled by the Division related to the transition of members, to support a seamless transition.

F. Be responsible for payment of all outstanding obligations for medical care rendered to members.

G. Be responsible for the provision of a monthly claims aging report including Incurred But Not Reported (IBNR) amounts (as outlined in the Division Notification).

H. Be responsible for the provision of Quarterly and Audited Financial Statements up to the date specified by the Division.

I. Be responsible for the provision of encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed. Cooperate with reinsurance audit activities on prior Contract years.

J. Cooperate with the Division to complete and finalize any open and pending reconciliations.

K. Be responsible for the submission of Quality Management and Medical Management reports as required by contract, as appropriate, to provide information on services rendered up to the date of contract expiration or termination including Quality Of Care (QOC) concern reporting and investigations based on the date of service.

L. Be responsible for participation in and closing out Performance Measures and Performance Improvement Projects as required.

M. Provide a monthly accounting and disposition of Member Grievances and Provider Claim Disputes as outlined in the Division notification.

N. Be responsible for the retention, preservation, and availability of all records, including, but not limited to those records related to member grievance and appeal records, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement and those covered under HIPAA, as required by Contract, State and Federal law, including but not limited to, 45 CFR 164.530(j) (2) and 42 CFR 438.3(u).

O. Be responsible for the completion of existing third-party liability cases or making any necessary arrangements to transfer the cases to the Division authorized Third Party Liability (TPL) Contractor.

P. Be responsible for the following activities pertaining to member services and transitions:

1. Continue to serve enrolled members and provide all medically necessary covered services until the transition of all members is complete as specified by the Division.

2. Conduct all member transition activities in accordance with the Division requirements.

3. Cooperate with AdSS which are receiving members, to support seamless transition of all member services.

4. Transfer member data to AdSS which are receiving members using a file format and dates for transfer of member data specified by the Division.

5. The cost, if any, of reproducing and forwarding medical records.

Q. Return to the Division any funds advanced to the AdSS for coverage of members for periods subsequent to the date of termination within 30 days of the Contract termination.

R. Make available all data, information and reports collected or prepared by the AdSS in the course of performing its duties and obligations under the Contract to the Division within 30 days following expiration or termination of the Contract or such other period as specified by the Division.

For Contract terminations, the AdSS will, in addition to the above requirements:

1. Be liable for costs incurred by the Division in re-procuring materials or services under the Contract.

2. Be liable for costs associated with the transition of its members to a different AdSS.

Contract Expiration or Termination Plan

A. The AdSS must submit a Contract Expiration or Termination Plan to the Division, for approval. The Plan must be submitted to the designated Operations and Compliance Officer, within 30 days of the Division expiration/termination notice to the AdSS.

B. The Contract Expiration or Termination Plan must include, but is not limited to, the following:

1. A description of the AdSS process for ensuring compliance with all responsibilities delineated in the Contract including retention of sufficient staff to conduct business operations through the time period specified by the Division.

2. The designation of a Contract Transition Coordinator.

3. Timeline for submission of all required deliverables for the term specified by the Division.

4. Communications to all subcontractors and members related to the Contract expiration/termination, including a timeline for notification.

5. The method for transferring member data and disposition of any related medical records.

6. A Member Transition Plan to support a seamless transition of members including but not limited to members with:

   a. Significant medical or behavioral health conditions such as, a high-risk pregnancy or pregnancy within the last trimester, Serious Mental Illness (SMI), the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

   b. Ongoing services such as daily in home care, behavioral health services, dialysis, pharmacy, medical supplies, transportation, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition.

   c. Conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth.

   d. Prior authorized services including but not limited to scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, nursing home admission or Home and Community Based (HCBS) Placements, Continuing prescriptions, Durable Medical Equipment (DME), and medically necessary transportation orders.

   e. Significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, ventilator services.

   f. High needs/high costs.

7. In addition, the Member Transition Plan must also support a seamless transition for those members who present ongoing concerns to State and Federal entities and/or the media.

Release of AdSS Requirements after Contract Expiration or Termination

The AdSS remains responsible for all activities associated with the Contract expiration or termination until official written release from the Division has been granted.

A. The AdSS must submit to the Division, a written request for release.

B. The Division will provide an official written release upon satisfaction of activities associated with the Contract expiration or termination including, but not limited to, the following:

1. Audited Financial Statements inclusive of a balance sheet
2. Payment of all outstanding medical obligations for medical care rendered to members.
3. Encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed.
4. Reinsurance audit activities on prior contract years.
5. Finalization of any open or pending reconciliations
6. Performance Bond or Bond Substitute.

444 NOTICE AND APPEAL REQUIREMENTS (SERIOUS MENTAL ILLNESS APPEALS)

EFFECTIVE DATE: April 29, 2020

REFERENCES: ACOM Policy 444 - Notice and Appeal Requirements (Serious Mental Illness Appeals)

Attachment A - AHCCCS Notice of SMI Grievance and Appeal Procedure

Attachment B - Notice of Legal Rights for Persons with Serious Mental Illness

Attachment C - Notice of Decision and Right to Appeal (for Individuals with an SMI)

Attachment D - Notice of Discrimination Prohibited

This Policy applies to Administrative Services Subcontractors (AdSS). The purpose of this Policy is to ensure that persons seeking or receiving behavioral health services and persons seeking an SMI eligibility determination are provided notice and the opportunity to Appeal as required under Arizona Administrative Code (A.A.C.) R9-21-401.

DEFINITIONS

A. Action – The Denial or Limited Authorization of a requested behavioral health service. This includes:

1. Type or level of service;
2. Reduction, suspension or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide covered services in a timely manner;
5. Failure to act within established timeframes for resolving an Appeal or complaint and providing notice to affected parties; and
6. Denial of the Title XIX/XXI eligible person's request to obtain covered services outside the network.

B. Appeal – A request for review of a decision made by the Division, an AdSS, or an AdSS provider.

C. Denial - The decision to deny a request made by, or on behalf of, a behavioral health recipient for the authorization and/or payment of a covered service.

D. Limited Authorization - A service authorization that falls short of the original request, with respect to the duration, frequency, or type of service requested.

E. Prior Authorization - A process used to determine in advance of provision whether or not a prescribed procedure, service, or medication will be covered. The process is intended to act as a safety and cost savings measure.

F. Qualified Clinician - A behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified professional.

G. Reduction of Service - A decision to reduce the frequency or duration of an ongoing behavioral health service. A Reduction of Service does not include a planned change in service frequency or duration that is initially identified in the person's service plan and agreed to in writing by the person receiving services or his/her legal guardian.

H. Suspension of Service - A decision to temporarily stop providing a behavioral health service.

I. Termination of Service - A decision to stop providing a covered behavioral health service.

POLICY

A. APPLICABILITY

This policy applies to decisions made by the AdSS or the AdSS subcontracted providers regarding the need for, the timely provision of, or the continuation of services, and charges or co-payments for behavioral health services.

This Policy does not apply to:

1. Allegations of rights violations made by enrolled persons with a Serious Mental Illness (See ACOM Policy 446).
2. Actions or decisions that deny, suspend, reduce, or terminate a person's services or benefits as a result of changes in state or federal law which require an automatic change, or in order to avoid exceeding the state funding legislatively appropriated for those services or benefits.
3. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services.
4. TXIX Appeals of an Action affecting services subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services.

B. PROCEDURES

1. General Requirements for Notices and Appeals

a. Computation of Time

i. In computing any time prescribed or allowed by this policy, the period begins the day after the act, event or decision occurs. The time period shall be calculated using calendar days. Weekends and legal holidays are counted in the computation. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

b. Language and Format Requirements

i. Notice and written documents generated through the Appeals process shall be available in each prevalent, non-English language spoken within the geographic service area;

ii. The AdSS or AdSS subcontracted providers shall provide oral interpretation services at no charge to the behavioral health recipient to explain information contained in the notice or as part of the Appeal process for all non-English languages; and

iii. Notice and written documents generated through the Appeals process shall be available in alternative formats, such as Braille, large font, or enhanced audio, and take into consideration the special communication needs of the person applying for or receiving behavioral health services, and notice and written documents shall be written using an easily understood language and format.

c. Delivery of Notices

i. All notices and Appeal decisions identified herein shall be personally delivered or mailed by certified mail to the required party at their last known residence or place of work. In the event that it may be unsafe to contact the person at his or her home address, or the person has indicated that he or she does not want to receive mail at home, the alternate methods identified by the person for communicating notices shall be used.

d. Prohibition of Punitive Action

i. The Division, the AdSS, and the AdSS subcontracted providers are prohibited from taking punitive action against persons exercising their right to Appeal.

2. Notice Requirements

a. Notices pursuant to this section shall be delivered to:

i. The member/guardian/designated representative. For members identified as in need of Special Assistance, the person designated to meet the Special Assistance needs shall be notified.

b. Provision of notice shall be evidenced by retaining a copy of the notice in the comprehensive clinical record of the person receiving or requesting services.

3. Notices for persons being evaluated for or who have been determined to have SMI

a. The AdSS AdSS or AdSS subcontracted provider shall provide Attachment A (AHCCCS Notice of SMI Grievance and Appeal Procedure) to each person at the time of evaluation for an SMI eligibility determination.

b. The AdSS and AdSS' subcontracted providers shall provide a copy of Attachment B (Notice of Legal Rights for Persons with Serious Mental Illness) at the time of admission to the agency for evaluation or treatment. The person receiving this notice shall acknowledge in writing the receipt of the notice and this written acknowledgement shall be retained in the person's comprehensive clinical record. The AdSS and the AdSS' subcontracted providers shall post Attachment B (Notice of Legal Rights for Persons with Serious Mental Illness), in both English and Spanish, so that it is readily visible to persons visiting the agency.

c. The AdSS shall provide Attachment C (Notice of Decision and Right to Appeal (for Individuals with an SMI)) when:

i. Initial eligibility for SMI services is determined. The notice shall be sent within three days of the eligibility determination;

ii. A decision is made regarding fees or waivers thereof;

iii. An assessment report, Service Plan or Inpatient Treatment and Discharge Plan is developed, provided or reviewed;

iv. A decision is made to modify the service plan or to deny, reduce, suspend or terminate a service that is a non-Title XIX/XXI covered service. No notice is required when the requested service requires a physician's order, and the denial, reduction, suspension or termination is due to the physician's refusal to order the service. Decisions to modify the service plan to deny, reduce, suspend or terminate a service that is Title XIX/XXI covered requires notification. Notice shall be provided at least 30 days prior to the effective date of the change unless the person agrees to the change in writing, or a Qualified Clinician determines that the Action is necessary to avoid a serious or immediate threat to the health or safety of the person receiving services or others;

v. A decision is made that the person is no longer eligible for SMI services; or

vi. A PASRR determination, in the context of either a preadmission screening or an annual resident review, is made which adversely affects the person.

d. Every AdSS and AdSS subcontracted provider shall post Attachment D (Notice of Discrimination Prohibited), so that it is readily visible to persons visiting the agency and shall provide a copy of this form to the person at the time of discharge from the agency.

4. Notices for Non-SMI/Non-Title XIX/XXI populations

a. Notice is not required to persons who are not eligible for Title XIX/XXI or SMI services for service decisions under this policy.

5. Appeal Requirements

a. AdSS Responsibility in appeals

i. Upon request, the AdSS and AdSS Subcontracted providers shall provide assistance in explaining the Appeal process or in reducing the Appeal in writing to the appropriate Appeal form.

b. Who May File an Appeal (i.e., the Appellant)

i. An adult applying for or receiving services, his or her legal guardian, guardian ad litem, designated representative or attorney, and for persons identified as in need of Special Assistance, this includes the person designated to meet the Special Assistance needs,

ii. A legal guardian, parent with legal custody, court-appointed guardian ad litem, or court-appointed attorney of a person under the age of 18 years,

iii. A state or governmental agency that has executed an Intergovernmental Agreement/Interagency Service Agreement (IGA/ISA) with The Division for the provision of behavioral health services to persons served by the governmental agency, but which does not have legal custody or control of the person, to the extent specified in the ISA/IGA between the agency and the Division, or,

iv. A provider acting on the behavioral health recipient's behalf and with the written authorization of the recipient.

6. Appeal Process for Persons with a Serious Mental Illness

a. The Appeal process for persons designated as SMI applies to all persons who have been determined SMI eligible and to persons disputing an SMI eligibility determination,

b. Title XIX/XXI eligible persons with a SMI who are Appealing an Action (see definition) affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI Appeal process as outlined in Contract, or the Appeal process for persons with a SMI, and

c. An Appeal may be filed for one or more of the following. An Appeal may not be filed when the contested decision involves a request for a service that requires a physician's order, and the physician refuses to order the service:

i. The Appeal process for persons designated as SMI applies to all persons who have been determined SMI eligible and to persons disputing an SMI eligibility determination,

ii. Title XIX/XXI eligible persons with a SMI who are Appealing an Action (see definition) affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI Appeal process as outlined in Contract, or the Appeal process for persons with a SMI, and

iii. An Appeal may be filed for one or more of the following. An Appeal may not be filed when the contested decision involves a request for a service that requires a physician's order, and the physician refuses to order the service:

iv. Recommended services identified in the assessment report, SP or ITDP,

v. Actual services to be provided, as described in the ISP, plan for interim services or ITDP,

vi. Access to or prompt provision of services,

vii. Findings of the clinical team with regard to the person's competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance,

viii. Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP,

ix. Application of the procedures and timeframes for developing the ISP or ITDP,

x. Implementation of the ISP or ITDP,

xi. Decision to provide service planning, including the provision of assessment or case management services to a person who is refusing such services, or a decision not to provide such services to the person,

xii. Decisions regarding a person's fee assessment or the Denial of a request for a waiver of fees,

xiii. Denial of payment of a claim,

xiv. Failure of the Contractor or AHCCCS to act within the timeframes regarding an Appeal, or

xv. A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the person.

7. Continuation of SMI services

a. If the Appeal relates to the modification or termination of a behavioral health service, the service under Appeal shall continue pending the resolution of the Appeal through the final agency decision, unless:

i. A Qualified Clinician determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual, or,

ii. The person or guardian, if applicable, agrees in writing to the modification or termination.

8. Standard Appeal Process

a. Within five working days of receipt of an Appeal, the AdSS shall inform the appellant in writing that the Appeal has been received and of the procedures that will be followed during the Appeal,

b. If the AdSS refuses to accept a late Appeal or determines that the issue may not be appealed the AdSS shall inform the appellant in writing that he or she may, within 10 days of his/her receipt of the health plan decision, request an Administrative Review of the decision with the Division. This does not include those Actions or decisions described in Section A of this Policy to which this Policy does not apply, and,

c. If a timely request for Administrative Review is filed with the Dvision of the AdSS's decision as specified in this Policy, The Division shall issue a final decision of within 15 days of the request.

9. Informal Conference with the Contractor

a. Within seven days of receipt of an Appeal, the AdSS shall hold an informal conference with the appellant (including any guardian, guardian ad litem, designated representative, attorney, or case manager or other representative of the service provider, as applicable). If the appellant has been identified as needing Special Assistance, the AdSS shall contact the appellant's advocate, if no advocate has been assigned to the appellant, the AdSS shall contact AHCCCS Office of Human Rights and request that an advocate be present to assist the client during the informal conference and any other part of the Appeal process,

b. The Contractor shall schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice,

c. The informal conference shall be chaired by a representative of the Contractor with authority to resolve the issues under Appeal, who shall seek to mediate and resolve the issues in dispute,

d. The AdSS representative shall record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented, and identify any unresolved issues for further Appeal,

e. If the issues in dispute are resolved to the satisfaction of the appellant, the AdSS shall issue a dated written notice to all parties, which shall include a statement of the nature of the Appeal, the issues involved,

the resolution achieved and the date by which the resolution will be implemented,

f. If the issues in dispute are not resolved to the satisfaction of the appellant and the issues in dispute do not relate to the appellant's eligibility for behavioral health services, the appellant shall be informed that the matter will be forwarded for further Appeal to the Division for informal conference, and of the procedure for requesting a waiver of the the Division informal conference,

g. If the issues in dispute are not resolved to the satisfaction of the appellant and the issues in dispute relate to the appellant's eligibility for SMI services or the appellant has requested a waiver of the the Division informal conference in writing, the AdSS shall:

i. Provide written notice to the appellant of the process to request an administrative hearing,

ii. Determine at the informal conference whether the appellant is requesting the AdSS to request an administrative hearing on behalf of the appellant and, if so, file the request with the Division within three days of the informal conference,

iii. For a person who is in need of Special Assistance, send a copy of the Appeal, results of informal conference and notice of administrative hearing referenced in this Policy to the the Division Office of Human Rights, and

iv. If the appellant fails to attend the informal conference and fails to notify the AdSS of his or her inability to attend prior to the scheduled conference, the AdSS shall reschedule the conference in accordance with the requirements of this Policy. If the appellant fails to attend the rescheduled conference and fails to notify the AdSS of his or her inability to attend prior to the rescheduled conference, the AdSS shall close the Appeal docket and send written notice of the closure to the appellant.

1) If the appellant requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, the AdSS may re-open the Appeal and proceed with the informal conference.

2) For all Appeals unresolved after an informal conference with the Contractor, the Contractor shall forward the Appeal case record to the Division within three days from the conclusion of the informal conference.

10. Informal Conference

a. Unless the appellant waives an informal conference with the Division, or the issue on Appeal relates to eligibility for SMI services, the Division shall hold a second informal conference within 15 days of the notification from the AdSS that the Appeal was

unresolved.

i. At least five days prior to the date of the second informal conference, The Division shall notify the participants in writing of the date, time and location of the conference,

ii. The informal conference shall be chaired by a representative of the Division who shall seek to mediate and resolve the issues in dispute,

iii. The Division representative shall record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented, and identify any unresolved issues for further Appeal, and

iv. If the issues in dispute are resolved to the satisfaction of the appellant, the Division shall issue a dated written notice to all parties, which shall include a statement of the nature of the Appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

1) For a person in need of Special Assistance, the Division shall send a copy of the informal conference report to the Division Office of Human Rights.

v. If the issues in dispute are not resolved to the satisfaction of the appellant, the Division shall:

1) Provide written notice to the appellant of the process to request an administrative hearing,

2) Determine at the informal conference whether the appellant is requesting the Division to request an administrative hearing on behalf of the appellant and, if so, file the request within three days of the informal conference,

3) For a person who is in need of Special Assistance, send a copy of the notice as specified in this Policy to the Division Office of Human Rights,

4) In the event the appellant fails to attend the informal conference and fails to notify the Division of his or her inability to attend prior to the scheduled conference, the Division may issue a written notice, within three working days of the scheduled conference, which contains a description of the decision on the issue under Appeal and advises the appellant of his or her right to request an Administrative Hearing, and,

5) In the event the appellant requests the Appeal be re-opened due to not receiving the informal conference

notification and/or due to other good cause, the Division may re-open the Appeal and proceed with the informal conference.

11. Requests for Administrative Hearing

a. A written request for hearing filed with the Division shall contain the following information:

i. Name of the appellant and person receiving services (if different) and the case docket number),

ii. The decision being appealed,

iii. The date of the decision being appealed, and,

iv. The reason for the Appeal.

b. In the event a request for administrative hearing is filed with the AdSS, the AdSS shall ensure that the written request for hearing, Appeal case record and all supporting documentation is received by the Division within 3 days from such date, and

c. Administrative hearings shall be conducted and decided pursuant to A.R.S. §41- 1092 et seq.

12. Expedited Appeals

a. At the time an Appeal is initiated, the appellant may request an expedited Appeal in writing. The AdSS shall accept requests to expedite an Appeal for good cause, and for the following:

i. The Denial of admission to or the termination of a continuation of inpatient services, or

ii. A Denial or termination of crisis or emergency services.

b. Within one day of receipt of a request for an expedited Appeal, the AdSS shall:

i. Inform the appellant in writing that the Appeal has been received and of the time, date and location of the expedited informal conference, or,

ii. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal and that the appellant may, within three days of the AdSS's decision, request an Administrative Review of the AdSS's decision from The Division.

c. If the appellant requests an Administrative Review on a timely basis, the Division shall complete the review and issue a written decision within one day from the date of receipt. The decision of the Division shall be final.

13. AdSS Expedited Informal Conference

    a. Within two days of receipt of a written request for an expedited Appeal, the AdSS shall hold an informal conference to mediate and resolve the issues in dispute.

14. Division Expedited Informal Conference

    a. Within two days of notification from the Contractor, the Division shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference, in which case the Appeal shall be forwarded within one day to the Division to schedule an administrative hearing, or

    b. If the Divisions informal conference is not waived, and it fails to resolve the Appeal, within one day of the informal conference, the Appeal shall be forwarded to the Division to schedule an administrative hearing.

445 SUBMISSION OF HEARING REQUESTS

REVISION DATE: 10/11/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2901, A.R.S. § 41-1092 et seq, ACOM Policy 445, Attachment A

PURPOSE

This Policy sets forth guidance for Administrative Services Subcontractors (AdSS) contracted with the Division of Developmental Disabilities (Division)when submitting a request for a hearing to the Arizona Health Care Cost Containment System Administration.

DEFINITIONS

1. "Arizona Health Care Cost Containment System (AHCCCS)" - means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
2. "Appeal" means the review of an adverse benefit determination.
3. "Business Day" means the same as Day – Business/Working.

4. "Day – Business/Working" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
5. "Director's Decision" - The final administrative decision under A.R.S. § 41-1092(5).
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "State Fair Hearing" - An administrative hearing under A.R.S. A.R.S. § 41-1092 et seq.
8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. HEARING REQUEST FILE SUBMISSION TIMEFRAMES

The AdSS shall submit hearing requests within the following timeline:

1. Expedited Member Appeal hearing requests must be submitted no later than one Business Day from receipt of the expedited hearing request.

2. Standard Member Appeal hearing requests must be submitted no later than three Business Days from receipt of the hearing request.
3. Claim dispute hearing requests must be submitted no later than three Business Days from receipt of the hearing request.

B. HEARING REQUEST FILE SUBMISSION METHOD

1. The AdSS shall submit the hearing request files to the Division's Office of Administrative Review for Member Appeals and provider claim dispute hearing requests
2. The AdSS must submit a standard Submission of Request for Hearing Form ACOM Policy 445, Attachment A with the Member Appeal or provider claim dispute file.

C. HEARING FILE CONTENT

Hearing files must be submitted with all of the following:

1. Submission of Request for Hearing Form, ACOM Policy 445, Attachment A,
2. Request for Hearing,
3. Notice of Appeal Resolution or Notice of Decision,

4. Appeal or Claim Dispute,
5. Notice of Adverse Benefit Determination for Member Appeals; and
6. Signed Appointment of Representative for Member Appeals.

D. SUBMISSION OF REQUEST FOR HEARING FORM ATTACHMENT A

1. The AdSS shall include an accurately completed Submission of Request for Hearing Form ACOM Policy 445, Attachment A that:
   a. Is the first page of the file submission, and
   b. Have all applicable fields completed.
2. The AdSS shall not submit a request without an accurately completed Submission of Request for Hearing Form ACOM Policy 445, Attachment A.
3. The Division shall forward the hearing request file to the AHCCCS Office of General Counsel (OGC).

E. SUBMISSION OF ADDITIONAL SUPPORTING DOCUMENTS

Any changes or additional information to be included to the issue or citations after a hearing file is submitted to AHCCCS, shall be:

1. Filed by the AdSS with the Office of Administrative Hearing as a Motion to Amend the Notice of Hearing, and
2. Copied to the Office of Administrative Review.

SUPPLEMENTAL INFORMATION

1. The Submission of Request for Hearing Form ACOM Policy 445, Attachment A submitted by the AdSS is used to identify the hearing issue and applicable citations.
2. Additional information or changes submitted to the Division or AHCCCS is not added to the Administrative record on the AdSS's behalf.
3. The Division and AHCCCS OGC reserve the right to make changes to the issue and any legal citations for accuracy.

446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. Title 32, Chapter 33; A.R.S. §§ 41-1092 et seq., A.R.S. § 36-550; A.A.C. R9-21-101(B), A.A.C. R9-21-403, A.A.C. R9-21-406, A.A.C. R9-21-410(B), ACOM Policy 444, AMPM Policy 960; ACOM Policy 446, Attachment A, AHCCCS Appeal or SMI Grievance Form (English and Spanish Versions)

This Policy applies to the Division's Administrative Services Subcontractors and outlines the process related to grievances and investigations concerning persons with a Serious Mental Illness (SMI).

This Policy does not apply to grievances or requests for investigation asserted by, or on behalf of, persons with an SMI to the extent the allegation asserts a violation relating to the right to receive services, supports, and/or treatment that are state-funded and are no longer funded by the state due to limitations on legislative appropriation.

Definitions

A. Abuse - The infliction of, or allowance of, another person to inflict or cause physical pain or injury, impairment of bodily function, disfigurement, or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody, or control of a member receiving behavioral health services or community services. Abuse also includes sexual misconduct, assault, molestation, incest, or prostitution of, or with, a member under the care of personnel of a mental health agency. - A.A.C. R9-21-101(B).

B. Administrative Appeal - An appeal to AHCCCS of a decision made by an AdSS as the result of a grievance.

C. Appeal - A request for review of an adverse decision by an AdSS.

D. Condition Requiring Investigation - An incident or condition that appears to be dangerous, illegal, or inhumane, including the death of a person with Serious Mental Illness.

E. Dangerous - A condition that poses or posed a danger or the potential of danger to the health or safety of a person with Serious Mental Illness.

F. Day – means calendar days, unless otherwise specified.

G. Grievance or Request for Investigation - A complaint that is filed by a person with Serious Mental Illness or other concerned person alleging a violation of an SMI member's rights or a condition requiring an investigation.

H. Illegal - An incident or occurrence that is or was likely to constitute a violation of a state or federal statute, regulation, court decision, or other law.

I. Inhumane - An incident, condition, or occurrence that is demeaning to a person with

Serious Mental Illness or that is inconsistent with the proper regard for the right of the person to humane treatment.

J. Mental Health Agency - Includes a regional authority, service provider, inpatient facility, or an agency that conducts screening and evaluation under A.A.C. Title 9, Chapter 21, Article 5, and A.A.C. R9-21-101(B)(47).

K. Preponderance of Evidence - A standard of proof that it is more likely than not that an alleged event occurred.

L. Serious Mental Illness - A condition as defined in A.R.S. § 36-550 diagnosed in persons 18 years and older.

M. Special Assistance - The support provided to a person determined to have a Serious Mental Illness who is unable to articulate treatment preferences and/or participate effectively in the development of the Planning Document, Inpatient Treatment and Discharge Plan (ITDP), or grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

Policy

For members who have been diagnosed with a Serious Mental Illness, the AdSS must conduct investigations into allegations of physical abuse, sexual abuse, and violations of rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a death of a member that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

General Requirements

A. The AdSS must respond to grievances and requests for investigations in accordance with this Policy and the requirements and timelines contained in A.A.C. Title 9, Chapter 21, Article 4.

B. In computing any period of time prescribed or allowed by this Policy, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

C. The AdSS must use a unique docket number for each grievance or request for investigation filed. The file and all correspondence generated must reference the docket number.

Resolving Grievances and Requests for Investigation

A. Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by an AdSS or one of its subcontracted providers and which does not involve a member death or an allegation of physical or sexual abuse, must be filed with and investigated by the AdSS.

B. Grievances or requests for investigation involving physical or sexual abuse or death must be filed with, and investigated by, AHCCCS.

C. The AdSS or its subcontractor must immediately take whatever action may be reasonable to protect the health, safety and security of any member, complainant or witness when a grievance or request for investigation is pending.

Grievance and Request for Investigation Process

A. Timeliness and Method for Filing Grievances and Requests for Investigation

1. A grievance or a request for investigation must be submitted to the AdSS or its subcontracted providers, orally or in writing, no later than 12 months from the date on which the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by AHCCCS or the AdSS, as applicable.

2. Within five days of receipt of a grievance or request for investigation, the AdSS must inform the person filing the grievance or request for investigation, in writing, that the grievance or request has been received.

3. Any employee or contracted staff of the AdSS or its subcontracted providers, must, upon request, assist a person receiving services, or his/her legal guardian, in making an oral or written grievance or request for investigation or direct the person to an available supervisory or managerial staff who will assist the person to file a grievance or request for investigation ((A.A.C. R9-21-403(F)).

4. If an AdSS or its subcontracted provider receives an oral grievance or request for investigation, it must accurately reduce it to writing on the AHCCCS Appeal or SMI Grievance Form (See ACOM Policy 446, Attachment A, Appeal or SMI Grievance Form, adopted by the Division for use by the AdSS).

B. Summary Disposition – AHCCCS or the AdSS may summarily dispose of a grievance or request for investigation without any notice or right for further review or hearing when:

1. The alleged violation occurred more than one year prior to the date the grievance or request is received, or

2. The grievance or request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in A.A.C. Title 9, Chapter

21, Articles 3 and 4.

C. Disposition Without Investigation - Within seven days of receiving a grievance or request for investigation, it may be resolved without conducting a full investigation if the matter:

1. Involves no material dispute as to the facts alleged in the grievance or request for investigation

2. Is frivolous, meaning that it:

   a. Involves conduct that is not within the scope of A.A.C. Title 9, Chapter 21

   b. Is impossible on its face

   c. Is substantially similar to conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated, or

3. Is resolved fairly and efficiently within seven days without a formal investigation.

   Within seven days of the receipt of the grievance or request for investigation, a written dated decision must be issued that explains the essential facts as to why the matter may be appropriately resolved without investigation and the resolution. The written decision must contain a notice of appeal rights and information to request assistance from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision must be sent to the person filing the grievance or request for investigation, to the AHCCCS OHR for persons who need Special Assistance, and to other parties as required by A.A.C. Title 9 Chapter 21, Article 4.

D. Conducting Investigations of Grievances

1. Investigations must be conducted pursuant to A.A.C. R9-21-406. The investigator must:

   a. Interview the person who filed the grievance and the person receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the person alleged to be the perpetrator of the rights violation, or physical or sexual abuse.

   b. If the person who is the subject of the investigation has been identified as needing Special Assistance, the investigator must contact the person's advocate; or if no advocate is assigned, the investigator must contact AHCCCS OHR, and request that an advocate be present to assist the person during the interview and any other part of the investigation process.

   c. Request assistance from the AHCCCS OHR if the person receiving

services needs assistance to participate in the interview and any other part of the investigation process.

d. Prepare a written report that contains at a minimum:

i. A summary for each individual interviewed of information provided by the individual during the interview conducted

ii. A summary of relevant information found in documents reviewed

iii. A summary of any other activities conducted as a part of the investigation

iv. A description of any issues identified during the course of the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation

v. A conclusion, describing those findings and/or factors that led to the conclusion, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence, and

vi. Recommended actions or a recommendation for required corrective action, if indicated.

2. Within five days of receipt of the investigator's report, AHCCCS's Deputy Director or the AdSS's CEO or designee will review the investigation case record and the report, and issue a written, dated decision that will:

a. Accept the report and state a summary of findings and conclusions, and any recommended actions or corrective action required, and send copies of the decision, subject to confidentiality requirements to the investigator, the AdSS, the person who filed the grievance, the person receiving services identified as the subject of the grievance (if different), the AHCCCS Office of Human Rights for a person in need of Special Assistance, and the applicable independent oversight committee. The decision will include a notice of the right to request an appeal of the decision within 30 days from the date of receipt of the decision. The decision will be sent to the grievant by certified mail or by hand-delivery, or

b. Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report within 10 days, absent extension.

3. Actions that may be taken or recommended, as indicated above, include:

a. Identifying training or supervision for, or disciplinary action against, an

individual found to be responsible for a rights violation or condition requiring investigation identified during the course of investigation

b. Developing or modifying a mental health agency's practices or protocols

c. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation

d. Imposing sanctions that may include monetary penalties, according to the terms of a contract, if applicable.

4. A grievant or the member who is the subject of the grievance, who disagrees with the final decision of the AdSS, may file a request for an administrative appeal with AHCCCS within 30 days from the date of the receipt of the decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the Division's decision.

5. If an administrative appeal is filed, the AdSS must forward the full investigation case record, which includes all elements described in A.A.C. R9-21-409(D)(1), to AHCCCS. The failure of the AdSS to forward a full investigation case record that supports the AdSS's decision may result in a summary determination in favor of the person filing the administrative appeal. The AdSS must prepare and send, with the investigation case record, a memo that states:

a. Any objections the AdSS has to the timeliness of the administrative appeal

b. The AdSS's response to any information provided in the administrative appeal that was not addressed in the investigation report, and

c. The AdSS's understanding of the basis for the administrative appeal.

6. Within 15 days of receipt of a timely filed administrative appeal, AHCCCS will review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and prepare a written, dated decision that either:

a. Accepts the investigator's report with respect to the facts as found, and affirms, modifies, or rejects the decision of the AdSS with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within 30 days from the date of receipt of the decision, must be sent to the appealing party, with copies of the decision provided to the AdSS, AHCCCS OHR, and the applicable independent oversight committee; or

b. Rejects the investigator's report for insufficiency of facts and remands the matter with instructions to the AdSS for further investigation and

decision. The AdSS must conduct further investigation and complete a revised report and decision to AHCCCS within 10 days, after which AHCCCS will render a final decision. Or AHCCCS may reject the investigator's report for insufficiency of facts and remand the matter with instructions to the AdSS for further investigation and the issuance of a revised AdSS's decision, directly to grievant or client who is the subject of the grievance, along with notification of the right to request a second administrative appeal to AHCCCS of the AdSS's revised decision within 30 days from the date of receipt of the revised decision.

7. Extensions of Time - If an extension of any time frame related to the grievance process is needed, the extension must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:

   a. The AdSS investigator or any other AdSS official responsible for responding to grievances must address the extension request to the AdSS Director or designee,

   b. The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address the extension request to the AHCCCS Deputy Director or designee,

   c. An AdSS request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance must be addressed to the AHCCCS Deputy Director or designee, and

   d. Requests for extension must be in writing, with copies to all parties.

Request for an Administrative Hearing

A grievant or person who is the subject of the grievance who is dissatisfied with a decision of AHCCCS may request an administrative hearing before an administrative law judge, within 30 days of the date of receipt of the decision.

A. Upon receipt of a request for a hearing, the hearing is scheduled and conducted according to the requirements in A.R.S. §§ 41-1092 et seq.

B. After the expiration of the timeframes for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals, the AdSS will take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report will be sent to the AHCCCS OHR for persons in need of Special Assistance.

Miscellaneous Matters Relating to the Grievance Process

A. In addition to a grievance or request for investigation that may be filed pursuant to this Policy and A.A.C. Title 9, Chapter 21, Article 4, a separate investigation into the death of a person receiving services must be conducted as described in Division Medical Policy Manual, Policy 960.

B. Grievance Investigation Records: The AdSS must maintain records in the following manner:

1. All documentation received related to the grievance and investigation process must be date-stamped on the day received.

2. A complete grievance investigation case record must be maintained for each case, and must include:

a. The original grievance/investigation request letter and the Appeal or SMI Grievance Form

b. Copies of all information generated or obtained during the investigation

c. The investigator's report, which will include:

- A description of the grievance issue

- Documentation of the investigative process

- Names of all persons interviewed

- Written documentation of the interviews

- Summary of all documents reviewed

- The investigator's findings, and

- Conclusions and recommendations.

d. A copy of:

- The acknowledgment letter

- Final decision letter

- Corrective action documentation, and

- Any information/documentation generated by an appeal of the grievance decision.

C. The AdSS must maintain all grievance and investigation files in a secure designated area and retain for at least five years.

D. The AdSS must maintain a public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

E. The AdSS must maintain confidentiality and privacy of grievance and investigations records.

F. Notice must be given to a public official, law enforcement officer, or other person, as

required by law, that an incident involving death, abuse, neglect, or threat to a person receiving services has occurred, or that a dangerous condition or event exists. Refer to AMPM Policy 960.

G. The AdSS must notify the Deputy Director of AHCCCS, or designee, when: (Refer to AMPM Policy 960)

1. A person receiving services files a complaint with law enforcement alleging criminal conduct against an employee.

2. An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a person receiving services.

3. An employee, contracted staff, or person receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a person receiving services.

448 HOUSING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-550; 24 CFR 582, 24 CFR 583, and the following:

- Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)
- ACOM Policy 448 Attachment A, AHCCCS Housing Application for Acquisition and/or Renovation or New Construction
- ACOM Policy 448 Attachment B, AHCCCS Housing Acquisition/Renovation Checklist,
- ACOM Policy 448 Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions
- ACOM Policy 448 Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement,
- ACOM Policy 444, Notice of Appeal Requirements (Serious Mental Illness Appeals)
- ADSS-Operations Policy 446,-Grievances and Investigations Concerning Persons with Serious Mental Illness.

Purpose

This Policy applies to Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (DDD, or the Division) to provide a guideline for the delivery of housing services, the development, implementation and management of housing programs and related funds for the eligible populations. [24 CFR Part 582 and 24 CFR Part 583]

Definitions

A. Arizona Department of Housing (ADOH) − A department established for state government in Arizona to assist in addressing needs for homes for working families. ADOH administers programs for Housing Partners who apply to the department for funding. The majority of the agency's programs are federally funded. The agency is also home to the Arizona Housing Finance Authority and the Arizona Home Foreclosure Prevention Funding Corporation.

B. Continuum of Care − A regional or local planning body that coordinates housing and services funding for homeless families and individuals as required by the U.S. Housing and Urban Development (HUD) Agency.

C. Department of Housing and Urban Development (HUD) − A U.S. government agency created in 1965 to support community development and home ownership. HUD does this by improving affordable home ownership opportunities, increasing safe and affordable rental options, reducing chronic homelessness, fighting housing discrimination by ensuring equal opportunity in the rental and purchase markets, and supporting vulnerable populations.

D. Homeless (HUD Definition) − A person is considered homeless only when he/she resides in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street)
- In an emergency shelter
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution
- Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and lacks resources and support networks needed to obtain housing
- Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing
    - For example, a person being discharged from prison after more than 30 days is eligible ONLY IF no subsequent residence has been identified and the person does not have money, family or friends to provide housing.
    - Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.

E. Homeless (Persons in these situations are not included in the HUD definition of or funding purposes) −

- Persons living in housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded
- Persons living with relatives or friends
- Persons staying in a motel, including a pay-by-the-week motel
- Persons living in a Board and Care, Adult Congregate Living Facility, or similar place
- Persons being discharged from an institution that is required to provide or arrange housing upon release, or
- Wards of the State, although youth in foster care may receive needed supportive services which supplements, but does not substitute for, the state's assistance.

F. Housing Acquisition and/or Renovation Programs − A housing program that provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). Eligible non-profit Housing providers work with the AdSS to locate properties, purchase and/or renovate them for the use of persons determined to have Serious Mental Illness following AHCCCS requirements, review and approval. The property is held for use of AHCCCS eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

G. Housing First − A Housing approach that works to quickly and successfully to connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

H. Housing Referral − A written authorization from the AdSS for the provision of covered services to an eligible member. The Housing Referral will constitute the agreement of the provider to provide services identified in the tenant's Individual Service Plan. Housing Referrals will be in such form and format determined by the AdSS.

I. HUD Housing Choice Voucher Program − The federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Individuals free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Housing choice vouchers are administered locally by Public Housing Agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

J. Independent Community Housing − A setting where a person can live either alone or with a roommate in a home or apartment without on-going daily supervision from behavioral health providers. Options include:

- HUD Section 8 programs through local Public Housing Authorities
- Low-income subsidized housing through local non-profit organizations
- Supportive Housing Programs funded with federal grants and administered by AdSS contracted housing providers
- State subsidized rental units, and
- Permanent Houses and apartments purchased with state funding.

K. Public Housing Authority (PHA) − HUD funded unit of local government that provides independent housing for low-income individuals and families. Program includes Section 8, Housing Choice Vouchers, and low rent units.

L. Rapid Housing − An intervention, informed by a Housing First approach that is a critical part of a community's effective homeless crisis response system. Rapid re-housing rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-

limited financial assistance and targeted supportive services. Rapid re-housing programs help families and individuals living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness, avoiding a near-term return to homelessness, and linking to community resources that enable them to achieve housing stability in the long-term. Rapid re-housing is an important component of a community's response to homelessness. A fundamental goal of rapid rehousing is to reduce the amount of time a person is homeless.

M. Section 8 − Section 8 is the more common name for the Housing Choice Voucher Program which is sponsored by HUD. Qualified applicants receive vouchers which are used to subsidize the cost of housing. These vouchers are awarded to individuals who meet certain income requirements. The goal of these programs is to provide affordable low-cost housing to low income occupants.

N. Serious Mental Illness (SMI) − A condition as defined in A.R.S. §36-550 diagnosed in persons 18 years and older.

O. Sponsor-Based Rental Assistance − Sponsor-based rental assistance provides a subsidy for rental assistance through contracts between the grantee and contracted sponsor organization. A sponsor may be a private nonprofit organization, or a community mental health agency established as a public nonprofit organization. Participants reside in housing owned or leased by the sponsor.

P. Supporting Housing Services − Services, as defined in the AHCCCS Behavioral Health Services Guide, that are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include:

- Utility subsidies
- Relocation services to a person or family for the purpose of securing and maintaining housing
- Employment services
- Budget and finance counseling, and
- Eviction prevention.

Q. Supportive Housing − Housing, as defined in 24 CFR Part 583, in conjunction with supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless persons with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless persons and families.

R. Tenant-Based Housing − A scattered-site program in which the tenant holds the lease and is directly responsible to the owner of the property. This program is comparable to the HUD Section 8 Housing Choice Voucher Program, but with modifications to meet the

needs of adults determined to have a Serious Mental Illness.

S. Traditional Housing – Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24 months.

Policy

A. General Housing Contracts Requirements

For the populations of persons determined to have a SMI or other eligible populations served by the AdSS (contingent upon available funding) and who are able to live independently, the AdSS must provide a number of programs to support independent living, such as rent subsidy programs, supportive housing programs and other transitional housing programs. Independent living must be supported with provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Housing programs must include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supportive housing services to maintain independent living.

The Contractor AdSS must maintain a sufficient number of dedicated staffs of housing professionals with knowledge, expertise, experience and skills and require housing subcontractors to employ a sufficient number of staffs with knowledge, expertise and experience to participate in and administer a variety of affordable housing programs for members. The AdSS must:

1. Require housing subcontractors to employ a sufficient number of staffs with financial management, screening and referral skills, knowledge of federal wait lists, grant writing knowledge for applying for new funds, and supportive services as required by HUD to maintain current HUD grants as they come up for renewal, and to fund future grants.

2. Submit plans describing the AdSS housing programs and submit periodic reports on housing programs, as outlined in Contract.

3. Develop and submit an Annual Housing Needs Assessment, that includes:

    a. A brief summary of the AdSS's Housing program history and/or current projects

    b. The specific eligibility group for any proposed new program and/or use of funds (e.g. SMI, GMH/SA, High Cost/High Needs Members) to include:

        i. A Program description

        ii. Barriers, trends and accomplishments in housing identified during the reporting period

        iii. Basis for need including supporting data and justification

        iv. Plan for identification of program candidates, and

        v. Collaborators.

4. Develop and submit for approval an Annual Housing Spending Plan for development, maintenance, use and acquisition of housing properties in a format specified by the Division and must at a minimum include:

    a. Project descriptions separated by population and funding source

    b. For each project the estimated number of new housing units and members housed and possible barriers

    c. Evidenced based best practices to be used improve housing capacity in responding to unmet housing needs and related issues; i.e. assessment scores

    d. All leveraged funds, their sources and collaborative efforts

    e. Project timeframes, and

    f. Monitoring and tracking process for each program.

5. Ensure that providers identify, and screen individuals determined to have SMI that satisfy Section 8 criteria and refer the prospective tenant to contracted Public Housing Authority.

6. Require providers to participate with the individual's treatment team in order to identify available housing units and to place the individual in an affordable appropriate living environment upon discharge from an institutional setting.

7. Comply with, requirements in ACOM Policy 444 for appeals related to supportive housing services.

8. Comply with AdSS Operations Policy Manual, Chapter 446 for Housing related grievances and requests for investigation for persons determined to have SMI.

B. Division Requirements for State Funding Supportive Housing Programs

The Division supports permanent supportive housing and has adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) model for permanent supportive housing programs.

1. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program are:

    a. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.

    b. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.

    c. Participation in services is voluntary and tenants cannot be evicted for rejecting services.

    d. House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or

otherwise interfere with a life in the community.

e. Housing is not time-limited, and the lease is renewable at tenants' and owners' option.

f. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.

g. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.

h. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.

i. Tenants have choices in the support services that they receive. Tenants are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.

j. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.

k. Support services promote recovery and are designed to help tenants choose, get, and keep housing, and

l. The provision of housing and the provision of support services are distinct.

2. The AdSS must comply with the following requirements to effectively manage limited housing funds in providing supportive housing services to eligible individuals. See the AHCCCS Covered Behavioral Health Services Guide for additional information on Supportive Housing. The AdSS must:

a. Accept all persons determined to have a SMI into a State Funded Housing Program subject to funding availability.

b. Utilize supportive housing allocations for eligible individuals and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for persons determined Title XIX/Non-Title XIX SMI persons, while another allocation may require it be used for those persons with GMH/SA eligibility.

c. Ensure safe and stable housing that is consistent with the member's recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.

d. Not actively refer or place individuals in a Homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other

similar facilities.

e. Provide the tenant with a 30-day notice at the time of the tenant's annual, recertification, if a rent payment is increased in state funded housing programs, The AdSS may charge up to, but not greater than, 30% of a tenant's income towards rent.

f. Not use supportive housing allocations for room and board charges in Residential Treatment settings. However, the AdSS may allow Residential Treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.

g. Not use supportive housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture. However, move-in assistance and eviction prevention services may be provided to those members in permanent housing. When move-in assistance is provided, assistance with deposits and payment for utilities must be prioritized over other methods of assistance, such as move-in kits or items consisting of pots and pans, dishes, sheets, etc. Subcontract with a non-profit organization that is eligible to serve as a grantee for HUD funded grant programs.

h. Ensure that their subcontracted providers doing business with agencies that have HUD grants, report data to the local Homeless Management Information System (HMIS) project manager on contract, to administer the HMIS data collection.

i. Ensure that contracted providers deliver a range of housing services and present available options for housing to persons determined to have SMI consistent with the individual's goals and needs in the Individual Service Plan.

j. Ensure that providers maintain all housing units currently in use, including units acquired through the State of Arizona housing funds specifically for members determined to have a SMI or other eligible populations served by the AdSS as funding permits.

k. Collaborate with State, County and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.

l. Develop new housing capacity, program initiatives and options when needed in collaboration with Division, ADOH and local HUD Continuum Of Care (COC).

m. Participate in the AHCCCS Quarterly Housing Meetings.

3. AdSSs awarded HUD funding are required to participate in the Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. The HMIS is used to coordinate care, manage program operations, and better serve clients.

4. The AdSS must develop and make available to providers the AdSS's contact information to receive additional guidance and requirements regarding these programs.

5. AdSS housing programs are required to include specialized housing units to meet the needs of persons who are difficult to place in the community partly due to crime free/drug free ordinances and specific behavioral health related service need including substance use disorders.

6. The AdSS must provide persons determined to have SMI who are discharged from the Arizona State Hospital, supervisory care homes or unlicensed board and care homes, with housing options that promote independent living.

7. The AdSS must require providers to participate with the member's treatment team in order to identify available housing units and to place the member in an affordable appropriate living environment upon discharge from an institutional setting.

8. The AdSS must advocate for persons determined to have SMI who are homeless and those released from Residential Treatment and Board and Care facilities to obtain housing units.

9. The AdSS must develop and make available to the providers policies and procedures regarding specific housing programs/funding and related requirements.

C. AdSS Monitoring Requirements of Subcontractors

The AdSS must monitor Housing subcontractors through the following activities:

1. Monitor providers for compliance with federal requirements of the SAMHSA Permanent Supportive Housing Fidelity Monitoring and HUD homeless grants.

2. Conduct regular inspections of housing units including tenant living situations to determine whether the individual has access to basic needs and whether the living environment is safe, secure and the least restrictive environment consistent with the treatment goals in the Individual Service Plan. Ensure contracted housing providers conduct these inspections also, and

3. Conduct a Housing Inventory of housing providers and tenants. This inventory must be submitted in the format and time required by the Division and must include:

   a. The number and types of housing programs.

   b. Number of units.

   c. Fund source for those units, and

   d. Populations served for each unit.

4. Develop and maintain an accounting system of all individuals in its housing program and of its housing and support service providers, and when requested or by Division Contract requirements, submit the data in a format approved by the Division.

5. Demonstrate that the AdSS's staff and provider housing program staff have received training and can demonstrate competency in the following:

Clinical & Administrative Managers will demonstrate:

Knowledge of the basic concepts found in the Federal Fair Housing Law and the Arizona Landlord Tenant Act as they apply to members and their contracted providers by passing a post-test conducted after an orientation session.

Behavioral Health Professionals (BHP's), Behavioral Health Technicians (BHT's) & Behavioral Health Paraprofessionals (BHPP's) will demonstrate competency, by passing a post-test after training, in the following areas:

a. Knowledge of basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords

b. The general rights of members afforded by these laws, and

c. The principles and availability of Housing support services.

Case Managers will demonstrate that they capably:

Understand the basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords.

a. Explain lease requirements and rights of tenancy to Members in language they understand and can act upon,

b. Visit members and schedule service appointments at their homes consistent with the law,

c. Determine eviction risk and arrange for skill and or support service assistance to Members in coordination with Housing Providers,

d. Document and involve the Member in investigating complaints originated by the Member or Landlord, and

e. Pass a post test conducted after training and thereafter during routine clinical supervision.

Housing Specialists and Case Managers will also demonstrate that they can capably conduct and use the current and emerging tools and best practices such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) by passing a post test conducted after Specialized Training program and thereafter during routine clinical supervision.

D. Requirements for Collaboration and Partnerships with Federal Housing Programs

1. The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. On May 20, 2009, a law was enacted to reauthorized HUD's McKinney-Vento Homeless Assistance Programs which in part outlined assistance programs for the homeless. The bill, known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, made numerous changes to HUD's homeless assistance programs to include the following:

   a. Significantly increased resources to prevent homelessness,

   b. Established incentives on the use of rapid re-housing programs, especially for homeless families,

   c. A revised definition of "Permanent Supportive Housing" for people experiencing chronic homelessness to establish an industry standard, and to add "families" to the definition of "chronically homeless", and

   d. The option for rural communities to apply under a different set of guidelines that may offer increased flexibility and assistance with capacity building.

2. The purpose of the COC Homeless Assistance Program is to reduce the incidence of homelessness in COC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act.

   The HUD HEARTH COC became effective August 31, 2012 and includes:

   a. Codifying the COC process

   b. Expanding the definition of homelessness,

   c. Focusing selection criteria more on performance,

   d. The HEARTH Act consolidates the programs formerly known as the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) Program, and the Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Program into one grant program: the COC program,

   e. The COC Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness,

   f. The AdSS is required to work in collaboration with the Arizona Department of Housing (ADOH), the Division and all Arizona HUD COCs to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD COC Homeless Assistance Programs awarded

throughout the State including but not limited to the HUD Housing Choice Voucher Program, and

g. AdSS's who administer the federal HUD Housing Choice Voucher Program must ensure the following:

i. Tenants pay 30% of their adjusted income towards rent.

ii. Vouchers are portable throughout the entire country after one year.

iii. Permanent housing is obtainable for individuals following program rules.

iv. The program is accessed through local Public Housing Authorities through a waiting list.

v. Initial screening is conducted by the Public Housing Authority; however, the final decision is the responsibility of the landlord, and

vi. A Crime Free - Drug Free Lease Addendum is required.

E. AHCCCS Requirements for State Housing Acquisition and/or Renovation Programs

The AHCCCS Housing Acquisition and/or Renovation program provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). The AdSS subcontracts with eligible non-profit Housing providers to locate properties, purchase and/or renovate them for the use of Division members in accordance with Division requirements, review and approval. The property is held for use of Division eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

1. The following conditions apply:

a. The AdSS must administer the AHCCCS Property Acquisition and Renovation Program through subcontracts with or partnerships with non-profit entities that have the capacity, experience, and knowledge of low-income housing programs, available funding streams and resources for supportive housing for adults determined to have SMI, and other eligible populations served by the AdSS (contingent upon available funding).

b. The AdSS must have prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division, and

c. For Acquisition and/or renovation of real property purchased by the AdSS's subcontractors with funds provided by the Division, excluding net profits earned under the Contract, the AdSS must complete the following:

i. Attachment A, the AHCCCS Housing Application for Acquisition and/or Renovation or New Construction

ii. All required documents to include the funding source used, prior to the purchase of any new property leveraged with funds provided through the Division, and when applicable, a Notice of Real Property Transaction, which must include the following:

- Copies of Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions (CC&Rs) recorded with the County Recorder's Office (the CC&Rs will cover a period of extended as indicated in the CC&R table based on use and costs)
- The funding source(s) used to purchase the property, specifically whether the purchase is to be made with funds provided through the Division and/or other matched funds
- The financing arrangements made prior to purchase the property
- Prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division
- A deed containing the use restrictions and covenants, conditions, or restrictions that ensures the property is used solely for the benefit of members and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions, and
- All documents as required in Attachment B, AHCCCS Housing Acquisition/Renovation Checklist.

d. The Division requires that the AdSS adopt Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement as minimum requirements for all agreements for Housing Acquisition and/or Remodel or New Construction made between the AdSS and Housing Contractors using State Funds.

449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

REVISION DATES: 4/13/22, 9/15/21
EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01; A.A.C. R9-10-101

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) whose contract includes this requirement. The purpose of this policy is to ensure the timely provision of behavioral health services to children eligible for Title XIX services who are residing with an out-of-home caregiver or children in out-of-home dependency with Department of Child Safety (DCS), as specified throughout this policy, and to adopted children in accordance with A.R.S. § 8-512.01.

DEFINITIONS

Adoptive Parent means any adult who is a resident of Arizona, whether married, unmarried, divorced or legally separated, who has adopted a child. For purposes of this policy, the adoptive parent is that of a child who is eligible under Title XIX of the Social Security Act.

Arizona Department of Child Safety (DCS) is the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.
2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Behavioral Health Out-of-Home Treatment means highly individualized treatment services and support interventions to meet the needs of each child and their family. When community-based services are not effective in maintaining the child in their home setting, or safety concerns become critical, the use of out-of-home treatment services can provide essential behavioral health interventions to stabilize the situation. The primary goal of out-of-home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to his/her home and community settings.

Crisis means an acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior.

Crisis Services means services that are community based, recovery-oriented, and member focused that work to stabilize members as quickly as possible to assist them in returning to

their baseline of functioning.

Member for purposes of this policy includes children residing with out-of-home caregivers, children in out-of-home dependency with DCS, and adopted children.

Out-of-Home Caregiver for purposes of this policy is where a child in DCS custody resides (i.e., kinship care, foster care, a shelter care provider, a receiving home, independent living program or group foster home).

Rapid Response is a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health needs and to refer the child for additional assessments through the behavioral health system. (Refer to AdSS Medical Policy 541.)

POLICY

The Administrative Services Subcontractor (AdSS) shall ensure timely provision of all behavioral health services for members enrolled with the DDD Health Plan. The AdSS shall provide coordinated care between the out-of-home caregiver or adoptive parent(s), all providers, and DCS, as appropriate.

A. GENERAL REQUIREMENTS

1. To meet the needs of members residing with out-of-home caregiver, children in out-of-home dependency with DCS, and adopted children, the AdSS shall:

    a. Ensure services delivered are provided as specified in AdSS Operations Policy 417, and

    b. Ensure the availability of a telephone line, with designated staff, adequately trained on the provisions of this policy and the procedures in place to address calls.

B. REQUEST FOR BEHAVIORAL HEALTH OUT-OF-HOME TREATMENT

1. After a request is made to place a member in behavioral health out-of-home treatment, the AdSS shall issue a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include, but are not limited to, Behavioral Health Facilities as specified in A.A.C R9-10-101. If the AdSS determines there is insufficient information to make a determination, the AdSS shall document all substantive efforts to obtain required information within the 72-hour timeframe. If the request for behavioral health out-of-home treatment is denied, the AdSS shall ensure medically necessary alternative services are provided. BHRF denials by the AdSS shall be sent to the Division Utilization Management Unit for secondary review by the Behavioral Health Medical Director.

2. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment,

the AdSS shall coordinate with the hospital to ensure an appropriate and safe discharge plan. The discharge plan shall include recommended follow-up services, including recommendations made by the Child and Family Team (CFT). For additional requirements regarding discharge planning refer to the AdSS Medical Policies 580 and 1020.

3. The AdSS shall collaborate with DCS and the Support Coordinator to ensure an appropriate alternative for the member to be discharged when:

   a. It is unsafe for the member to return to the out-of-home caregiver or adoptive parent(s), and/or

   b. It is unsafe for the out-of-home caregiver or adoptive parent(s) for the member to return.

4. The AdSS shall issue a Notice of Adverse Benefit Determination (NOA), as specified in AdSS Operations Policy 414, for any adverse action related to the request for any adverse action related to the request for behavioral health out-of-home treatment.

5. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria was not met but there was not a safe discharge plan in effect to meet the needs and safety of the member and the out-of-home caregiver or adoptive parents. In these cases, the AdSS is responsible for payment regardless of principal diagnosis on the claim and may negotiate with the hospital for an appropriate rate.

C. BEHAVIORAL HEALTH APPOINTMENT STANDARD

1. Upon notification from an out-of-home caregiver or adoptive parent that a recommended behavioral health service is not provided to a member (as specified in AdSS Operations Policy 417), the AdSS shall:

   a. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to the Health Plan Customer Service (Mercy Care 800-624-3879 and United Healthcare 800-348-4058), as applicable;

   b. Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the AdSS;

   c. Obtain the name and contact information of the identified non-contracted provider of service, if applicable, to verify their AHCCCS registration; and

   d. Obtain information needed to determine medical necessity of requested services not received.

2. For services provided by a non-contracted provider, the AdSS shall:

a. Not deny claims submitted based solely on the billing provider being out of network, and

b. Reimburse clean claims at the lesser of 130% of the AHCCCS Fee-For-Service Rate or the provider's standard rate and as specified in AdSS Operations Policy 203.

c. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

D. EDUCATION

1. The AdSS is responsible for providing education to providers, members, families, and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to the following areas:

   a. Rights and responsibilities as delineated in A.R.S. §8-512.01,

   b. Trauma-informed care,

   c. Navigating the behavioral health system,

   d. Coordination of care as specified in this policy,

   e. Covered services,

   f. Referral process including Arizona Families First (Family in Recovery Succeeding Together; AFF),

   g. The role of the AdSS,

   h. The role of DCS as applicable, and

   i. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

2. The AdSS shall provide training and education to primary care providers regarding the behavioral health referral process.

3. All AdSS member information shall meet the requirements of AdSS Operations Policy 404.

4. The Division reserves the right to verify education programs when performing oversight of the AdSS.

E. REQUIREMENTS FOR CHILDREN IN THE CUSTODY OF DCS

In addition to the requirements above, the AdSS shall also adhere to the requirements included in this section:

1. Telephone Line

   a. Ensure the availability of a telephone line, with designated staff, that is

responsible for handling incoming calls after business hours related to delivery of services, including failure of an assessment team to respond within two hours, and

b. Designated staff shall be adequately trained on the provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There shall be processes in place for staff to:

i. Address barriers to care,

ii. Directly contact the crisis services vendor and/or provider,

iii. Track and report calls as specified throughout Policy, and

iv. Report the above information to the Children Services Liaison.

2. Continuity of Services

a. The AdSS are responsible for continuation and coordination of services the member is currently receiving.

b. If the member moves into a different county because of the location of the out-of-home caregiver, the AdSS must allow the member to continue any current treatment in the previous county and/or seek any new or additional treatment in the current county of residence regardless of the AdSS provider network.

3. Children Services Liaison

a. The AdSS shall designate an individual whose role is to serve as the member's single point of contact for accepting and responding to:

i. Inquiries from the out-of-home caregiver, adoptive parent, or providers,

ii. Issues and concerns related to the delivery of and access to behavioral health services for members,

iii. Collaborate with the out-of-home caregiver and adoptive parents to address barriers to services, including nonresponsive crisis providers, and

iv. Resolve concerns received in accordance with grievance system requirements.

b. The Children Services Liaison shall:

i. Provide the number for crisis services and afterhours telephone line in their outgoing voicemail message and email,

ii. Provide an expected timeframe for return calls in their outgoing voicemail message and email,

iii. Respond to all inquiries as indicated by need or safety but no later than one business day, and

iv. Follow up on all calls received by the afterhours telephone line.

c. The AdSS shall ensure the Children Services Liaison contact information is:

i. Provided to DDD and DCS for distribution,

ii. Prominently placed on the member page of the AdSS' website, and

iii. Included in the Member Handbook.

d. The AdSS shall ensure calls received by the Children Services Liaison that meet the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

F. TRACKING AND REPORTING

1. The AdSS shall:

a. Monitor, as specified in Contract, an Access to Services Report using Attachment A to ACOM 449:

b. Monitor on a monthly basis, and submit as specified in Contract, the number of calls and emails received by the Children Service Liaison and the afterhours line related to children residing with out-of-home caregiver or children in out-of-home dependency with DCS specific to this Policy (Attachment B to ACOM 449), and

c. Monitor on a monthly basis, and submit as specified in Contract, a Rapid Response Reconciliation reporting all Rapid Response information for children in DCS custody (Attachment B). The AdSS shall perform a reconciliation of members placed in DCS custody in contrast to those who have received a Rapid Response service. For any identified members in DCS custody who have not been engaged in behavioral health services, the AdSS shall ensure a Rapid Response service is delivered. For any identified members in DCS custody who are already receiving or otherwise are engaged in behavioral health services, the AdSS shall ensure an assigned service provider contacts the member and caregiver to conduct an assessment of the current status.

G. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division oversight activities including but not limited to the following methods to ensure compliance with this policy and policies referenced within this policy:

1. Annual Operational Review of related standards including but not limited to:
    a. AdSS has policies and procedures in place and demonstrates compliance to ensure members in foster care receive behavioral health services in alignment with this policy and AdSS 417.
    b. AdSS demonstrates compliance with the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.
    c. AdSS provides evidence of training and education provided to primary care providers regarding the behavioral health referral process.
    d. AdSS monitors for evidence in the medical record and the member's individual service plan that medically necessary services were determined by a qualified behavioral health professional.
2. Receive and review deliverable reports to ensure compliance and address service gaps or non-compliance. Submit collated data received from the AdSS and submit reports as required by contract to AHCCCS.
    a. AHCCCS Deliverable Attachment A to ACOM 449
    b. AHCCCS Deliverable Attachment B to ACOM 449
    c. AHCCCS Deliverable Attachment A to ACOM 417
3. Conduct a cadence of oversight meetings with each AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.
4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

470 MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 12-2297; 45 CFR 164.530(j)(2)

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS will maintain all records for five years from the date of final payment under contract with the Division unless a longer period of time is required by law.

For retention of the member's medical records, the AdSS will ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider must retain the member's medical records according to the following:

A. If the member is an adult, the AdSS will retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the AdSS.

B. If the member is under 18 years of age, the AdSS will maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the AdSS, whichever date occurs later.

The AdSS will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j) (2).

If the AdSS contract with the Division is completely or partially terminated, the records relating to the work terminated must be preserved and made available for five years from the date of any such termination. Records that relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the AdSS contract with the Division, or costs and expenses of the AdSS contract with the Division to which exception has been taken by the Division, must be retained by the AdSS for five years after the date of final disposition or resolution thereof.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: January 18, 2023

REFERENCES: 42 CFR § 438.62(b); A.R.S.§ 36-551; AMPM 1022; AMPM 541

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop a process for justice system reach-in care coordination activities, to support facilitating transition of members who have chronic and/or complex care needs out of jails and prisons, into communities.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means a person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.
2. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to

reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

3. "Justice System Liaison" for the purpose of this policy means a Division staff person who is located in Arizona and is the single point of contact for justice system stakeholders, such as jails/prisons/detention facilities, courts, law enforcement, and community supervision agencies. This position is responsible for ensuring care coordination of justice-involved members and for oversight and reporting of Justice System reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system. This includes, but is not limited to, sequential intercept modeling, crisis system utilization, and

specialty court programs.

POLICY

A. JUSTICE REACH-IN

1. Administrative Services Subcontractors shall notify the Division's Justice System Liaison, upon becoming aware that a Division member has become an inmate of a public institution.

2. The AdSS shall assist the Justice System Liaison in reach-in care coordination efforts, for members who have been incarcerated for 20 days or longer and have an anticipated release date.

3. The AdSS shall establish care management protocols for members involved in reach-in care coordination, which include but are not limited to members who have substance abuse disorder and/or meet medical necessity criteria to receive Medication Assisted Treatment (MAT), as consistent with AMPM 1022.

4. The AdSS shall notify the Division upon becoming aware that the incarcerated member's enrollment has not been suspended

to allow the Division to adjust eligibility dates, based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division.

5. The AdSS shall also utilize the renewal date information to identify incarcerated members who may have missed their eligibility redetermination dates while incarcerated causing a discontinuance of benefits, and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

6. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) to provide care management to members

7. The AdSS shall begin reach-In care activities upon knowledge of a member's anticipated release date and shall include education regarding care, services, resources, appointment information, subcontracted provider and care management contact information.

8. The AdSS shall monitor progress and submit a monitoring

progress report throughout the year as specified in the current Contract.

5000 REINSURANCE POLICY

REVISION DATE: 11/8/2023
EFFECTIVE DATE: December 15, 2021
REFERENCES: Section F3, Contractor Chart of Deliverables; 42 U.S.C. § 1396b (i); 42 USC § 1396d(r)(5); 42 CFR § 441.35; 42 CFR § 433.135 et seq.; A.R.S. § 36-2903; A.R.S. § 8-512; Title XIX/XXI; A.A.C. R9-22-1001; A.A.C. R9-22-720; AHCCCS Reinsurance Manual; AHCCCS Contract; DDD Health Plans Contract; ACOM 408; ACOM 414; AMPM 1620-I; AMPM 310-DD; AMPM 300-2A; DDD Medical Policy Manual, Policy 310-DD; AdSS Operations Manual, Policy 414; AdSS Medical Manual, Policy 1001

PURPOSE

The purpose of this policy is to outline the requirements the Administrative Services Subcontractors (AdSS) must meet to request Reinsurance reimbursement from the Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Adjudicated Claim" means a claim that has been received and processed by the AdSS which resulted in payment or denial of payment.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following: 1. Claims processing, including pharmacy claims, 2. Pharmacy Benefit Manager (PMB), 3. Dental Benefit Manager, 4. Credentialing, including those for only

primary source verification (i.e., Credential Verification Organization [CVO]), 5. Management Service Agreements, 6. Medicaid Accountable Care Organization (ACO), 7. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and 8. CHP and DDD Subcontracted Health Plan.

3. "Administrative Services Subcontractor" or "AdSS" means a person, individual, or entity who holds an Administrative Services Subcontract.
4. "Adverse Benefit Determination" means the denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.
5. "AHCCCS State Plan" means the written agreement between the State of Arizona and Centers for Medicare and Medicaid Services (CMS), which describes how the Arizona Health Care Cost Containment System (AHCCCS) meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
6. "Behavioral Health Services" or "BHS" means physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

7. "Biologic Drugs" means products produced by biotechnology. These drugs are referred to as biologicals, biological drugs, or biopharmaceuticals.
8. "Case" means a record for a Member that is composed of one or more Adjudicated Encounters.
9. "Case Type" means a description of the type of Reinsurance being paid to the AdSS based on the Member's medical condition and eligibility. Case Types include, but are not limited to DES, Hemophilia, von Willebrand Disease, Gaucher's Disease, Biologic or high cost specialty drugs, transplants, and High Cost Behavioral Health Services.
10. "Catastrophic Reinsurance" means reimbursement, full or partial, depending on the Case Type, from the Division to the AdSS for the cost of care associated with certain medical conditions and specific drugs described in the Contract, AMPM, and DDD policy.
11. "Clean Claim Status" or "Clean Encounter" means a claim or Encounter that may be processed in the AHCCCS Prepaid Medical Management Information System (PMMIS) without obtaining additional information from the Contractor of service or from a third party and has passed all of the Encounter and Reinsurance edits within the 15 month timely

filing deadline. This does not include claims being appealed or claims that are the subject of a grievance, under investigation for fraud or abuse, or claims under review for medical necessity.

12. "Coinsurance" means the percentage rate established each Contract Year by AHCCCS, at which the Division will reimburse the AdSS for covered services above the Deductible.
13. "Contract" means, for the purposes of this policy, the legal written agreement that the Division has with AHCCCS for providing health care coverage to Members who are eligible for ALTCS. This coverage includes physical health services and Behavioral Health Services.
14. "Contractor" or "Division", for the purposes of this policy, means an organization or entity that has a prepaid capitated contract with AHCCCS to provide goods and services to Members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and Federal law and regulations.
15. "Contract Year" means the twelve-month period beginning on October 1st through and including September 30th for Reinsurance. The

Contract Year may not correspond with the term of a Contract as specified in Section A of an entity's Contract with AHCCCS.

16. "Deductible" means the annual amount established each Contract Year by AHCCCS, of Reinsurance covered services that must be paid and encountered by the AdSS for each individual Member before the AdSS receives Reinsurance payments from the Division.
17. "DES Case Type" means certain covered inpatient facility services as described in the Contract, AMPM, and this policy that may qualify for Reinsurance reimbursement.
18. "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" means covered services for Members under 21 to correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act (Federal Law Subsection 42 USC 1396d (a)). Services are covered under EPSDT even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

19. "Encounter" means a record of health care related service that is a mirror image of a claim and is rendered by a provider or providers registered with AHCCCS to a Member who is enrolled with the Division on the date of service.
20. "Gaucher's Disease" means an inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
21. "Hemophilia" means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of hemophilia - A, B, and C. The severity of hemophilia is related to the amount of clotting factor in the blood.
22. "Hemophilia" means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of Hemophilia - A, B, and C. The severity of Hemophilia is related to the amount of clotting factor in the blood.
23. "High Cost Behavioral Health" or "BEH" means specialized mental health services for ALTCS Members that were discontinued under

Catastrophic Reinsurance, unless the Member was approved prior to October 1, 2007 and was active on September 30, 2007.

24. "Member" means the same as "client" as defined in A.R.S. § 36-551.

25. "Notice of Adverse Benefit Determination" means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the AdSS regarding the service authorization request and includes the information required by this Policy.

26. "Prepaid Medical Management Information System" or "PMMIS" means the AHCCCS mainframe pricing system of record that the Division uses for accessing the Reinsurance System.

27. "Prior Period Coverage" or "PPC" means the period of time prior to the Member's enrollment, during which a Member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a Member is enrolled with the Division.

28. "Prospective Coverage" means the period of time from when the AdSS receives notification the Member has been assigned to their plan and is expected to be capitated for the Member.

29. "Regular Reinsurance" means a partial reimbursement from AHCCCS to the Division for covered inpatient facility services (DES Case Type) as described in the Contract, AMPM, and DDD policy.
30. "Reinsurance" or "RI" means a stop-loss program provided by AHCCCS to the Division for the partial reimbursement of covered medical services incurred for a Member beyond an annual Deductible level.
31. "Reinsurance Payment Cycle" means the monthly updating of Reinsurance files in PMMIS for payment processing starting the first Wednesday of the month from 5:00 p.m. until the following Wednesday morning.
32. "Reinsurance System" means the PMMIS application for accessing Reinsurance Case data.
33. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

34. "Skilled Nursing Facility" or "SNF" means a nursing facility for those Members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.
35. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for AHCCCS benefits."Von Willebrand Disease" means an inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

POLICY

A. GENERAL REINSURANCE REIMBURSEMENT REQUIREMENTS FOR ALL CASE TYPES

1. The AdSS shall comply with the terms and conditions of the Administrative Services Subcontract with the Division.
2. The AdSS shall be responsible for the annual Deductible levels as determined by AHCCCS for covered medical services for each Member for the Contract Year.
3. The AdSS shall submit Reinsurance requests to the Division for Reinsurance covered services incurred beyond the annual

Deductible level for Members enrolled with the AdSS on a capitated basis.

4. The AdSS shall ensure Encounters meet the following criteria to qualify for Reinsurance reimbursement:
    a. The Encounter is approved and adjudicated within required time frames per the AHCCCS Contract and this policy;
    b. The Encounter associates to a Reinsurance Case;
    c. The Encounter is medically necessary;
    d. The service is non-experimental;
    e. The service is cost effective; and
    f. The service does not exceed an established cost threshold.
5. The AdSS shall not submit final Reinsurance claims which cross over Contract Years.
6. The AdSS shall base reimbursement of all covered Reinsurance Encounters on the following, unless costs are paid under a sub-capitated arrangement as outlined in subsection (8):
    a. Costs paid by the AdSS;
    b. Net of interest;
    c. Penalties;

d. Discounts;

e. AHCCCS Coinsurance rates;

f. Medicare payment; and

h. Third Party Liability (TPL) payment.

7. The AdSS shall base reimbursement of Reinsurance Encounters for costs paid under a sub-capitated arrangement on the following:

a. The lower of the AHCCCS allowed amount;

b. Reported AdSS paid amount;

c. Net of interest;

d. Penalties;

e. Discounts;

f. AHCCCS Coinsurance rates;

g. Medicare payment; and

h. TPL payment.

8. The AdSS shall refer to the Reinsurance page on the AHCCCS website for current:

a. Deductible levels;

b. Coinsurance rates;

c. Eligibility requirements;

d. Documentation requirements;

e. Covered high cost or Biologic Drugs;

f. Required time frames for submitting documentation and requests;

g. Reinsurance forms;

h. AHCCCS Reinsurance policy;

i. Transplant rates and Contracts; and

j. Reinsurance processing training manual and instructions.

9. The AdSS shall coordinate benefits with first party, Medicare, and TPL payers as required by Division Operations Policy Chapter 4001 and by the AHCCCS Contract.

11. The AdSS shall submit requests for Reinsurance reimbursement to the Division by 5:00 p.m. if the due date lands on a business day; or by 5:00 p.m. the next business day, if the due date lands on a weekend or State-recognized holiday.

12. The AdSS shall comply with medical audits on Reinsurance Cases upon request from the Division.

B. REGULAR REINSURANCE (DES CASE TYPE) REQUIREMENTS

1. The AdSS shall submit reimbursement requests for the following Regular Reinsurance covered inpatient hospital services provided to Members:
    a. Acute care hospitals (provider type 02);
    b. Specialty per diem hospitals (provider type C4);
    c. Accredited psychiatric hospitals (provider type 71);
    d. Per diem rates for Skilled Nursing Facility (SNF) services provided within 30 days following an acute inpatient hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any Contract Year when:
        i. The SNF stay is the first continuous SNF stay post inpatient discharge; or
        ii. The second SNF admission follows an additional inpatient stay.
    e. Services specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".

2. The AdSS shall not request Regular Reinsurance from the Division for the following inpatient provider service types that are not covered by AHCCCS:
    a. Same day admit-and-discharge services;
    b. Mental health residential treatment centers;
    c. Subacute facilities; and
    d. Services that are not specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".
3. The AdSS may request Regular Reinsurance reimbursement for the Member’s Prospective Coverage and Prior Period Coverage (PPC) enrollment periods.
4. The AdSS shall not submit requests for Regular Reinsurance on the following types of claims:
    a. Final claims that cross over Contract Years; and
    b. Interim claims.
5. The AdSS shall request Regular Reinsurance consideration from the Division for the final claim associated with the full length of a Member's hospital stay as long as the days of the hospital stay do not cross Contract Years.

C. GENERAL CATASTROPHIC REINSURANCE REQUIREMENTS

1. The AdSS shall request from the Division partial reimbursement of Catastrophic Reinsurance for medically necessary covered services provided to Members for the following Case Types:
   a. Hemophilia;
   b. Von Willebrand Disease:
   c. Gaucher's Disease;
   d. Biologic or high-cost specialty drugs;
   e. High Cost Behavioral Health; and
   f. Case Types other than transplants exceeding $1 million.
2. The AdSS shall not pay Deductibles for Catastrophic Reinsurance Cases.
3. The AdSS shall request a new Catastrophic Reinsurance Case by submitting the following documents to the Division for initial review and submittal to AHCCCS within 30 days of the identification of the Member's initial diagnosis or enrollment with the AdSS:
   a. The Request for Catastrophic Reinsurance form; and
   b. Supporting clinical documentation.

4. The AdSS shall ensure the Member's medical condition meets the criteria in Sections D, E, and F prior to submitting a new request for a new Catastrophic Reinsurance Case to the Division.
5. The AdSS shall submit the following documentation to the Division within 30 days of the start of the Contract Year for continuation of previously approved Catastrophic Reinsurance Cases:
    a. The Request for Catastrophic Reinsurance form; and
    b. The Non-Transplant Catastrophic Reinsurance Member List form.
6. The AdSS shall provide the Division with supporting clinical documentation for previously approved Catastrophic Reinsurance Cases upon request.
7. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Catastrophic Reinsurance forms to the AdSS that submitted the request.
8. The AdSS shall utilize the AHCCCS Contract for Hemophilia factor and blood disorders as the authorizing payor.

9. The Division shall reimburse the AdSS for all medically necessary services provided during the Contract Year:
    a. The current Coinsurance Rate for Catastrophic Cases; or
    b. The AdSS's paid amount, whichever is lower, depending on the subcap/CN1 code on the Encounter.
10. The Division shall reimburse the AdSS Catastrophic Reinsurance retroactively for a maximum of 30 days from the date the request is received by the AHCCCS.
11. The AdSS shall be responsible for prior authorization and care coordination for all components covered under the Contract for their Members.
12. The AdSS shall submit Reinsurance requests to the Division for catastrophic claims that contain any PPC and Prospective Coverage.

D. CATASTROPHIC REINSURANCE REQUIREMENTS FOR BLOOD DISORDERS

1. The AdSS shall request Catastrophic Reinsurance for adjudicated Encounters for services provided to Members diagnosed with Hemophilia.

2. The AdSS shall request Catastrophic Reinsurance for Members diagnosed with the following von Willebrand Disease types only:
    a. Type 1 and Type 2A that do not respond to desmopressin (DDAVP);
    b. Type 2B, Type 2M, and Type 2N based on diagnosis only; and
    c. Type 3 based on diagnosis only.
3. The AdSS shall review clinical records to confirm the Member's type of von Willebrand's Disease and whether or not the Member has responded to a DDAVP medication prior to requesting Catastrophic Reinsurance.
4. The AdSS shall request Catastrophic Reinsurance for all Members diagnosed with Gaucher's Disease Type I.
5. The AdSS shall not request Catastrophic Reinsurance for Gaucher's Disease Type 2 and Type 3.

E. CATASTROPHIC REINSURANCE REQUIREMENTS FOR BIOLOGIC OR HIGH COST SPECIALTY DRUGS

1. The AdSS shall request Catastrophic Reinsurance to cover the cost of medically necessary Bologic and high cost specialty drugs for Members. .
2. The AdSS shall request Catastrophic Reinsurance for the covered Biologic and high cost specialty drugs listed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website.
3. The AdSS shall be reimbursed the following by the Division when a biosimilar or generic equivalent of a Biologic Drug is available and AHCCCS has determined that the biosimilar is more cost effective than the brand-name product:
    a. The current Catastrophic Coinsurance rate of the lesser of the Biologic or high cost or its biosimilar equivalent for Reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific Member.
    b. The current Catastrophic Coinsurance rate of the paid amount of the branded Biologic Drug if the AHCCCS Pharmacy and Therapeutics Committee mandates the

utilization of only the brand name Biologic or high-cost specialty drug rather than the biosimilar.

4. The AdSS shall be reimbursed the Catastrophic Coinsurance rate the lesser of the following by the Division in the instances in which AHCCCS has specialty Contracts, or when legislation and policy limits the allowable reimbursement,:
   a. The AHCCCS contracted or mandated amount;or
   b. The AdSS's paid amount.
5. The AdSS may submit requests for new biological drugs or high-cost specialty drugs to the Division for consideration for Reinsurance purposes.
6. The AdSS shall encounter all Biologic or high-cost specialty drugs on a Form C pharmacy claim to be eligible for Reinsurance.

F. CATASTROPHIC REINSURANCE REQUIREMENTS FOR HIGH COST BEHAVIORAL HEALTH

1. The AdSS shall request Catastrophic Reinsurance reimbursement from the Division for medically necessary covered services provided during the Contract Year for Members enrolled in the

High Cost Behavioral Health (BEH) Program prior to October 1, 2007.

2. The AdSS shall submit the following to the Division no later than 10 business days prior to the expiration of the current approval to request continuation of BEH Reinsurance reimbursement:
   a. The High Cost Behavioral Health Reinsurance form, located in the AHCCCS website reauthorization request; and
   b. Supporting medical documentation as required in AMPM 1620-I.
3. The AdSS shall comply with the 10 business day timeframe and documentation requirements as required in item 2 of this section or the Division will deny additional Reinsurance reimbursement.
4. The AdSS shall ensure Encounters for covered services provided to enrolled BEH Members are adjudicated to be eligible for Reinsurance reimbursement.
5. The AdSS shall ensure medical documentation substantiating the Member's treatment is provided in the least restrictive treatment setting to be eligible for Reinsurance.

6. The AdSS may request Reinsurance reimbursement for ALTCS behavioral health Members for medically necessary covered services provided during the Contract Year.

G. HIGH DOLLAR CATASTROPHIC REINSURANCE REQUIREMENTS- $1,000,000+

1. The AdSS shall request Reinsurance reimbursement for all medically necessary Reinsurance covered expenses provided in a Contract Year, after the Reinsurance Case total value meets or exceeds $1 million, which is comprised of:
   a. The total AdSS paid amount; and
   b. The Deductible.
2. The AdSS shall notify the Division once a Reinsurance Case total value reaches $1 million.
3. The AdSS shall submit the following to the Division once a Reinsurance Case total value reaches $1 million:
   a. Request to create Case Types:
      i. Catastrophic Regular Acute (DDC);
      ii. Catastrophic Hemophilia (CHM);

iii. Catastrophic Biological or high-cost specialty drug (CRB); or

iv. Catastrophic ALTCS (CLT).

b. List of Encounters in numerical order that are to be transferred to the DDC, CHM, CRB, or CLT Case.

4. The Division shall disqualify the AdSS from receiving reimbursement for Catastrophic Cases and related Encounters exceeding $1 million when the AdSS fails to do the following within 15 months of the end date of service:

a. Notify the Division of a Reinsurance Case reaching $1 million; or

b. Notify the AHCCCS Reinsurance Unit of Encounters that should be transferred; or

c. Adjudicate related Encounters.

H. TRANSPLANT REINSURANCE OVERVIEW

1. The AdSS shall request the AHCCCS contracted Coinsurance rate for transplant services from the Division for the cost of care for enrolled Members:

a. Age 21 years and older who meet transplant Reinsurance coverage criteria for the specific transplant types listed in AMPM 310-DD and the AHCCCS State Plan.

b. Under age 21, who under the EPSDT Program, are covered for all non-experimental transplants necessary to correct or ameliorate defects, illnesses, and physical conditions whether or not the particular non-experimental transplant is covered by the AHCCCS State Plan or listed in AMPM 310-DD.

2. The AdSS shall comply with the terms and conditions of the AHCCCS transplant specialty Contract.

3. The AdSS shall not pay Deductibles for Transplant Reinsurance Cases.

4. The AdSS shall request transplant Reinsurance at the current AHCCCS contracted rates located on the AHCCCS website for the following transplant components:

a. Outpatient transplant evaluation;

b. Donor search and harvesting of the donor cells for stem cell transplants;

c. Preparation and transplant; and

d. Post-transplant care (Days 1 – 30 and Days 31 – 60).

5. The AdSS shall notify the Division and AHCCCS when a Member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant.

6. The AdSS shall be responsible for the following when the AHCCCS transplant specialty is contract is used:

a. Prior authorization; and

b. Care coordination.

I. TRANSPLANT CASE CREATION REQUIREMENTS

1. The AdSS shall timely submit the following documentation to the Division within 30 days of the Member's first component of the transplant to request approval for Case activation and transplant Reinsurance from AHCCCS:

a. Request for Transplant Reinsurance form, located on the AHCCCS website;

b. Supporting clinical documentation; and

c. AdSS policy supporting the transplant.

2. The AdSS, prior to submitting the request for transplant Reinsurance to the Division, shall ensure the documentation listed in item 1 of this section confirms the transplant is:
    a. Medically necessary;
    b. Covered by AHCCCS;
    c. Considered the standard of care; and
    d. Not considered experimental.
3. The AdSS shall submit the Transplant Reinsurance Crossover List, located on the AHCCCS website, to the Division for AHCCCS approval of Members requiring continuation of previously approved transplant Reinsurance.
4. The Division may deny Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean Reinsurance claims; or
    b. Failure to submit the Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

5. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Transplant Reinsurance forms to the AdSS that submitted the request.
6. If the AdSS receives a request for transplant that is outside of the criteria required in AMPM 310-DD, the AdSS may consult an independent review organization to determine whether or not the requested transplant is considered the standard of care and is medically necessary.
7. If the AdSS determines the transplant request should be authorized as a result of the consultation with the independent organization, the AdSS shall:
    a. Inform the Division of the pending decision; and
    b. Submit a Request for Transplant Reinsurance form to the Division for review by AHCCCS within 30 days of the initiation of the first transplant component.
8. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant related medications prior to denying services.

9. If the AdSS denies the transplant based on medical necessity or coverage criteria, the AdSS shall issue a Notice of Adverse Benefit Determination as outlined in the AdSS Operations Policy Manual, Chapter 400, Policy 414.

J. REQUIRED TRANSPLANT CASE COMMUNICATION

1. The AdSS shall communicate the AdSS's transplant activity by submitting the Quarterly Transplant Log to the Division no later than 10 days after the end of each quarter.
2. The AdSS shall not alter or password protect the format of the Quarterly Transplant Log prior to submission to the Division, or the log will be rejected and considered as a nonsubmission.
3. The AdSS shall complete the Quarterly Transplant Log as follows:
    a. Highlight in yellow the Member's name and the cell(s) that contain information that has been changed or updated since the previous submission.
    b. Note in the Comments Section general comments, which may include:
        i. New activity,
        ii. Transplants that have been denied,

iii. Transplant Cases that are closed and rationale,

iv. Availability of TPL or Medicare if the transplant is not covered or the Member has no benefit remaining.

4. The AdSS shall submit to the Division the Quarterly Transplant Log with all the transplant activity from the previous Contract Year on or before October 10th of each year.

5. The AdSS shall remove all non-active Members from the Quarterly Transplant Log that is submitted for the new Contract Year on or prior to January 10th, to include:

   a. Members who expired.

   b. Members removed from the transplant wait list.

   c. Members who received a transplant prior to September 30th.

   d. Members who terminated with the AdSS.

   e.

6. The AdSS shall only include on the Quarterly Transplant Log transplant components that are covered and reinsurable by AHCCCS.

K. TRANSPLANT CLAIM REINSURANCE REIMBURSEMENT

1. The AdSS shall not request Regular Reinsurance reimbursement for a transplant that is determined by AHCCCS to be ineligible for transplant Reinsurance coverage.
2. The AdSS shall pay claims for all transplant services approved by the AdSS regardless of a denial of Reinsurance reimbursement from AHCCCS.
3. The AdSS shall not request Reinsurance reimbursement for the following transplants that are not eligible for Reinsurance coverage:
    a. Bone graft transplants;
    b. Corneal transplants; and
    c. Kidney transplants.
4. The AdSS may submit to the Division a request for Regular Reinsurance for transplants that do not qualify for transplant Reinsurance for consideration by AHCCCS.
5. The AdSS shall not request transplant Reinsurance reimbursement for Members who have TPL including:
    a. Medicare Part A; or

b. Medicare Parts A and B.

6. The AdSS may request transplant Reinsurance reimbursement, less any payments received from Medicare, for Members with Medicare coverage under the below circumstances:

   a. If the Member has Medicare Part A and has exhausted their Medicare Part A benefit including lifetime reserve days during a transplant stage, only that stage and subsequent stages may qualify for Reinsurance.

      i. If the Member chooses not to use their available lifetime reserve days, the transplant stages will not qualify for transplant Reinsurance.

   b. If the Member has Medicare Part B only.

   c. If the Member qualifies for partial transplant coverage, an explanation of benefits (EOB) with Medicare payments must:

      i. Balance with the Medicare payments in PMMIS; and

      ii. State that the Member has exhausted Medicare Part A.

7. The AdSS shall request transplant Reinsurance reimbursement if Medicare does not cover a transplant type based on the Member's diagnoses and the transplant type is an AHCCCS covered benefit.
8. The AdSS shall not request quick pay discounts or interest to transplant Reinsurance reimbursements.
9. The Division shall retroactively reimburse transplant Reinsurance to the AdSS a maximum of 30 days from the date the Request for Transplant Reinsurance form was received and approved by AHCCCS.
10. The AdSS shall submit clean Reinsurance claims to the Division no later than 15 months from the end date of service for each transplant component in order to receive transplant Reinsurance reimbursement.
11. The Division may deny transplant Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean transplant Reinsurance claims; or

b. Failure to submit the Request for Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

12. The AdSS shall file transplant Encounters with a CN1 code of 09 to ensure the Encounter associates to a Case.
13. The AdSS shall void and replace an incorrectly coded transplant Encounter with the correct CN1 code if there is more than 45 days before the 15 month timely filing deadline.
14. If there is less than 45 days before the 15 month timely transplant claim filing deadline, the AdSS shall
    a. Submit a request to the Division to manually associate transplant Encounters to the transplant Case; and
    b. Submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15 month timely filing deadline.
15. The AdSS shall request transplant reimbursement for adjudicated Encounters that are associated with the transplant Case.

16. The AdSS shall ensure billed amounts and AdSS paid amounts for adjudicated Encounters agree with the transplant facility's related claims and invoices to receive Reinsurance payment for transplant stages.
17. The AdSS shall request prorated calculations from the Division only when:
    a. Tandem transplants occur; or
    b. A member changes Health Plans, in the middle of a transplant stage.
18. To file a claim for Reinsurance reimbursement, the AdSS shall submit the following documentation to the Division:
    a. The Transplant Stage Invoice Cover Sheet, available on the AHCCCS website; and
    b. All required documents listed on the transplant checklist from the AHCCCS Reinsurance Processing Manual.
19. The AdSS shall recognize that timeliness for each stage payment is based on the latest adjudication date for the complete set of Encounters related to the stage.

L. REQUIREMENTS FOR TRANSPLANTS THAT SPAN CONTRACT YEARS

1. The AdSS shall recognize that the transplant stage Reimbursement rate is based on the end date of the stage.
2. The AdSS shall split a transplant stage spanning two Contract Years based on the actual dates within the two Contract Years.
3. The AdSS shall not split transplant Encounters spanning two Contract Years unless a transplant component exceeding 60 days exists.
4. The AdSS shall submit to the Division a Reinsurance Action Request Form to request the transfer of Encounter(s) spanning Contract Years to the Case based on the end date of the stage.

M. OUTLIER THRESHOLD COVERAGE FOR TRANSPLANTS

1. The AdSS may qualify for transplant outlier coverage when a specified contractual outlier threshold listed on the transplant rate sheets is met or exceeded.
2. The AdSS shall submit the following documentation to the Division to request consideration for transplant outlier coverage from AHCCCS:

a. Transplant Outlier Template form located on the AHCCCS website; and

b. The documentation listed in the outlier checklist from the AHCCCS Reinsurance Processing Manual.

N. CLAIM ENCOUNTER DOCUMENTATION AND TIMEFRAMES FOR TRANSPLANT CONTRACTS

1. The AdSS shall submit Clean Claims for each stage of the solid organ transplantation or hematopoietic cellular therapy to the Division no later than 15 months from the end date of service for each particular transplant stage.
2. The AdSS shall submit outlier claim components to the Division no later than fifteen 15 months from the end date of the last completed stage.
3. The AdSS shall submit the transplant Encounter file to the Division at least 45 days prior to the 15-month deadline to ensure that the adjudication meets the 15-month timeframe.
4. The Division shall deny the claim for transplant Reinsurance reimbursement if the AdSS submits the Encounter file less than

45 days before the 15-month timeframe and the adjudication has not been completed by the 15-month deadline.

5. The AdSS shall base the timeliness of the claim submission for each stage of the transplant based on the submission date for the complete set of Encounters related to the stage.
6. The AdSS shall base timeliness for each stage payment on the latest adjudication date for the complete set of Encounters related to the stage.

O. POST TRANSPLANT INPATIENT STAYS EXCEEDING 11 OR 61+DAYS

1. The AdSS shall apply the following requirements for continuous post-transplant inpatient care from the date of the prep and transplant component from day 11+ and for kidney transplants and from day 61+ for all other Case Types:
    a. The AdSS shall request reimbursement at 75% of the transplant per diem rate less the Deductible for claims or Encounters for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other Case Types for all Members.

b. The AdSS shall request outlier reimbursement when the cost threshold of the claim or Encounter for the continuous inpatient stay for day 11+ for kidney transplants and day 61+ for all other Case Types is met or exceeded.

c. The AdSS shall submit all day 11+ and day 61+ Encounters representative of the continuous inpatient stay to the Division prior to adjudication.

d. The AdSS shall split Encounters submitted for a day 11+ or day 61+ stage that spans Contract Years.

2. The AdSS shall submit the Day 11+ or 61+ Outlier Worksheet and Instructions form, located on the AHCCCS website, to the Division to request outlier reimbursement for transplant days 11+ and 61+ paid at the per diem rate pursuant to the AHCCCS transplant specialty contract at an established cost threshold.

P. TRANSPLANT TRANSPORTATION AND LODGING REINSURANCE REIMBURSEMENT REQUIREMENTS

1. The AdSS shall request Reinsurance reimbursement for transportation, room, and board at the AHCCCS allowable rates

for the transplant candidate or recipient, potential donor or donor and, if needed, one adult caregiver.

2. The AdSS shall submit a request to AHCCCS Reinsurance Finance using the Transplant Transportation Lodging form found on the AHCCCS website.

Q. MULTI-ORGAN TRANSPLANTS THAT ARE NOT COVERED IN THE AHCCCS SPECIALTY CONTRACTS

1. The AdSS may submit a request to the Division for authorization from AHCCCS for transplant Cases that overlap when a second transplant component is started within the timeframe of an established component.
2. If a Member requires a multi-organ transplant the AdSS shall request Reinsurance for the following:
    a. The preparation and transplant components for each organ when performed separately; and
    b. The post-transplant component that provides the AdSS with the highest reimbursement and covers the longest period of time.

c. The surgical component of the second transplant, if a second covered organ transplant is performed during the post-transplant periods of the first transplant.

3. If approved by AHCCCS, the Division shall prorate the first transplant component and provide Reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1 - 30 post-transplant component and the day 31 - 60 post-transplant component.

4. The AdSS shall follow all applicable notification and claims filing requirements when requesting authorization for Reinsurance reimbursement for multi-organ transplants that are not covered by AHCCCS.

R. MULTI-SEQUENCE TRANSPLANTS

1. The AdSS may submit a request to the Division for authorization from AHCCCS for a transplant Case that requires an additional transplant for the same transplant type and an additional transplant sequence is started within the timeframe of an established component.

2. If a Member requires a second sequence transplant, the AdSS shall request Reinsurance for the initial transplant until the prep and transplant of the additional sequence occurs.
3. If an additional sequence is performed during the post-transplant periods of the previous transplant, the Division, upon approval from AHCCCS, shall reimburse the AdSS the prorated transplant component that coincides with the prep and transplant of the following sequence.
4. The AdSS shall follow all applicable notification and claims filing requirements when requesting Reinsurance reimbursement for multi-sequence transplants.

S. OUT OF STATE OR NON-CONTRACTED FACILITIES AND NON-CONTRACTED TRANSPLANTS

1. The AdSS, prior to the Member receiving out of state transplant services, shall request approval for Reinsurance from AHCCCS if the transplant services are:
   a. At non-contracted transplant facilities; or
   b. At out-of-state contracted facilities for non-contracted transplant types.

2. The AdSS shall obtain prior approval from the AHCCCS Medical Director for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service.
3. The AdSS shall, if prior approval is not obtained for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service:
    a. Incur costs for transplant services at the out of state facility;
    b. Be ineligible for either transplant or Regular Reinsurance; and
    c. Be ineligible for costs to be excluded from any applicable reconciliation calculations.
4. The AdSS shall request Reinsurance reimbursement for an approved transplant performed out of state at a non-contracted facility at 85% of the lesser of:
    a. The AHCCCS transplant contracted rate for the same organ or tissue, if available; or
    b. The AdSS paid amount.

5. The AdSS shall obtain prior approval from the AHCCCS Medical Director to use a non-contracted transplant facility or out-of-state contracted facility for a contracted transplant type that is available in state.
6. Depending on the unique circumstances of each AHCCCS approved out-of-state transplant, the AdSS shall request for consideration Reinsurance coverage at 85% of the AdSS's paid amount for comparable Case or component rates.

T. ENCOUNTER SUBMISSION REQUIREMENTS

1. The AdSS shall submit Encounters that associate to a Reinsurance Case to qualify for reimbursement of Reinsurance claims.
2. The AdSS shall ensure all Reinsurance-associated Encounters except as provided below for claim disputes, reach an adjudicated status within 15 months from the end date of service, or date of eligibility posting, whichever is later to be considered as timely filed:
    a. Replacements;
    b. Voids; and

c. New day Encounters.

3. The AdSS shall not manually replace or void Encounters during the Reinsurance Payment Cycle, or the AdSS may be subject to administrative action by AHCCCS.

4. The AdSS shall void Encounters that are recouped in full.

U. TIME LIMITS FOR FILING REINSURANCE CLAIMS

1. The Division shall pay the AdSS's Reinsurance claims for Regular Reinsurance Cases that are created automatically by PMMIS once the Encounter reaches an adjudicated status through the Encounter System.

2. The AdSS shall submit written requests for Reinsurance consideration for all other Reinsurance claims to the Division, except for Regular Reinsurance, using the forms and adhering to the claims submission time frames as required in this policy.

3. The AdSS shall submit Encounters that have attained clean status no later than 15 months from the end date of service.

4. The AdSS shall submit retro-eligibility Encounters that have attained a Clean Claim status no later than 15 months from the date of eligibility posting.

5. For Encounters undergoing Member appeal, provider claim dispute, grievance or other legal action, including an informal resolution originating from a request for a formal claim dispute or Member appeal, the AdSS shall ensure:
   a. The decision letter is received by AHCCCS no later than 90 days from the date of the final decision in that action; and
   b. The Encounters reach adjudicated status no later than 90 calendar days from the date of the final decision in that action, even if the 15-month deadline for attaining Clean Claim status has expired.
6. The Division shall not reimburse the AdSS Reinsurance if the AdSS fails to submit the adjudicated Encounter and the decision documentation within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director's decision, or other legal action, whichever is applicable.

V. ADMINISTRATIVE DISPUTE REQUIREMENTS

The AdSS shall follow the administrative dispute process as instructed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website, if the AdSS has exhausted Reinsurance refiling or

reconsideration processes and still disagrees with an action taken regarding a Reinsurance claim.

W. DIVISION OVERSIGHT OF THE ADSS

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
    a. Annual Operational Review of each AdSS,
    b. Review and analyze deliverable reports submitted by the AdSS, and
    c. Conduct oversight meetings with the AdSS for the purpose of:
        i. Reviewing compliance,
        ii. Addressing concerns with access to care or other quality of care concerns,
        iii. Discussing systemic issues, and
        iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

A. ENCOUNTER VOIDS AND REPLACEMENTS

1. When a void Encounter is submitted for a previously paid associated Reinsurance Encounter, the Reinsurance payment related to the voided Encounter will be recouped by AHCCCS.
2. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is less than the original AdSS paid amount, the difference will be recouped by AHCCCS.
3. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, the additional amount will be paid if the replacement Encounter was adjudicated and reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.
4. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS

paid amount, but the replacement Encounter was not adjudicated and did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same Encounter cycle, then the original AdSS paid amount will be recouped AHCCCS.

5. When a replacement Encounter is not submitted timely, and does not adjudicate to Encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of eligibility posting, whichever is later, within the same Encounter cycle it was submitted, and any of the following scenarios occur:
    a. The original Encounter was never associated to a Reinsurance Case; or
    b. The original Encounter was never associated to a Reinsurance Case; or
    c. The original Encounter associated with a Reinsurance Case but never reached pay status (PY); or
    d. The original Encounter has a previous Reinsurance paid amount of zero ($0.00):

i. The replacement Encounter is then subject to the Reinsurance timely filing limit edits:

1) H583 Reinsurance claim received more than 15 months after end date of service; or

2) H584 Reinsurance claim received more than 15 months after eligibility posting.

6. When a Replacement Encounter is:

a. Not submitted timely; and

b. Did not adjudicate; and

c. Did not reach approved status (CLM STAT 31) within the same Encounter Cycle; and

d. The original Encounter (Encounter identified on the 837 & NCPDP) Reinsurance paid amount is greater than $0:

i. The original AdSS paid amount will be recouped by AHCCCS.

7. The replacement Encounter consists of a two-step process:

a. The original AdSS paid amount will be recouped by AHCCCS.

b. The replacement Encounter transaction or process.

B. THIRD PARTY LIABILITY

1. Failure to comply with the TPL notification requirements may result in those sanctions specified in the AHCCCS Contract.
2. Should AHCCCS or its authorized representative identify third party recovery payments received by the Contractors that do not comply with the notification requirements in this section the following actions shall occur:
    a. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.
    b. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor's contingency fee schedule shall be added to the billing.
3. In addition, the Medicare Allowed, Medicare Paid, Third Party Payments and Value Code fields, as applicable, must be

completed when the Encounter is submitted for Reinsurance consideration.

C. MEDICARE

1. Medicare Calculations
    a. The Reinsurance system does not calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data is populated and mapped from the fields in the Encounter system.
    b. If there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter, then the Contractor must address these issues with the AHCCCS Encounter Unit.
2. PMMIS' view of Medicare
    a. The Encounter System categorizes Medicare as the type of Medicare appropriate for the stay. Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Part A dollars.

b. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Part B dollars.

c. Scenario Examples:

i. If the Member has only Medicare Part B and the Encounter is for an inpatient stay, then on the Encounter the Medicare Part B dollars should be placed under Other Coverage.

ii. If the Member has only Medicare Part B and the Encounter is for a doctor visit, then on the Encounter the Medicare Part B dollars should be placed under Medicare Coverage.

Form Type	Type of Medicare	Field on Encounter
I	Medicare Part A	Medicare
	Medicare Part B	Other Insurance
A	Medicare Part A	Does Not Apply
	Medicare Part B	Medicare
O	Medicare Part A	Other Insurance
	Medicare Part B	Does Not Apply

3. Medicare Lesser of Logic

a. The Medicare copay, Coinsurance, or Deductible, or

b. The difference between the Contractor's contracted rate and the Medicare paid amount.

4. Edit A510

a. Medicare Deductible and Coinsurance Exceeds Allowed Amount

i. Reinsurance Internal Pend

b. Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.

Quick Reference

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	**DEFINITION**	**SUB CAP**	**DESCRIPTION**
Blank		00	• No sub-capitated payment arrangement • Services: fee-for-service basis. (FFS) • Subscriber Exception code is 25 (PMMIS Screen Ri320), • Sub-Cap code is 05.
01	DRG	00	• Full sub-capitation arrangement • Services: Fully sub-capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
02	Per Diem	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
03	Variable PerDiem	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
04	Flat	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.

05	Capitated	01	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
06	Percent	00	• Partial Sub-Capitation arrangement • Services: Sub-Capitated provider that's excluded from the Sub-Capitated payment arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
09	Other	08	• Negotiated settlement • Services: Negotiated settlement, for example grievance settlement • Subscriber exception code is not 25 (PMMIS Screen Ri320)
09	Other	04	• Contracted Transplant Service • Services paid via catastrophic reinsurance • Subscriber exception code is 25 (PMMIS Screen Ri320)
	Identified by Filename	06	• Denied claim used to report valid Division services that are denied. For example, if a claim was denied for untimely submission.

Summary of Reinsurance Coverage

Case Type	***Deductible***	***Co-Ins***
RAC-Acute Contractors	$75,000	75%
RAC-DCS/CHPContractor	$75,000	75%
Catastrophic–Biologics/ High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High$	n/a	100%
Hemophilia	n/a	85%
Von Willebrand's	n/a	85%
Gaucher’s	n/a	85%
State Only Termination	n/a	100%
High Cost Behavioral Health	n/a	75%
DES - DDD	$75,000	75%
RAC-ALTCS – EPD MC PT.A 0-1,999	$10,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	$20,000	75%
AC-ALTCS – EPD No PT.A 0-1,999	$20,000	75%
RAC-ALTCS – EPD No PT.A 2,000+	$30,000	75%

Reinsurance Contract Year	Contract Year Ending
YR 38	10/1/194 – 9/30/20
YR 39	10/1/20 – 9/30/21
YR 40	10/1/21– 9/30/22
YR 41	10/1/22 – 9/30/23
YR 42	10/1/23 – 9/30/24
YR 43	10/1/24 – 9/30/25
YR 44	10/1/25– 9/30/26

Reinsurance Reports

The following reports (available in comma delimited or text format) are available via the Division FTP Server for AdSS' use and reference:

RI91L205 - Reinsurance Pend Report

This report is a summary of Case information for all active Cases that have pending Reinsurance Encounters during that reporting period. It lists the edit codes, edit descriptions, and edit counts.

RI81L310 - Reinsurance Remittance Advice Report

This report is generated after the monthly Reinsurance payment cycle and is a summary of all financial activity applied to only those Cases that were included in the payment cycle. Financial activity and Reinsurance Encounters

detailed on the Reinsurance Remittance Advice includes payments, replacements, voids, recoupments and denials.

RI91L105 - Reinsurance Case Summary Report

This report is a summary of Case information for all active cases during the monthly Reinsurance cycle and lists the status of all Reinsurance Encounters associated to each Reinsurance case. Also included are the Case level totals for the allowed amount, liability, Deductible, premium tax paid and total paid.

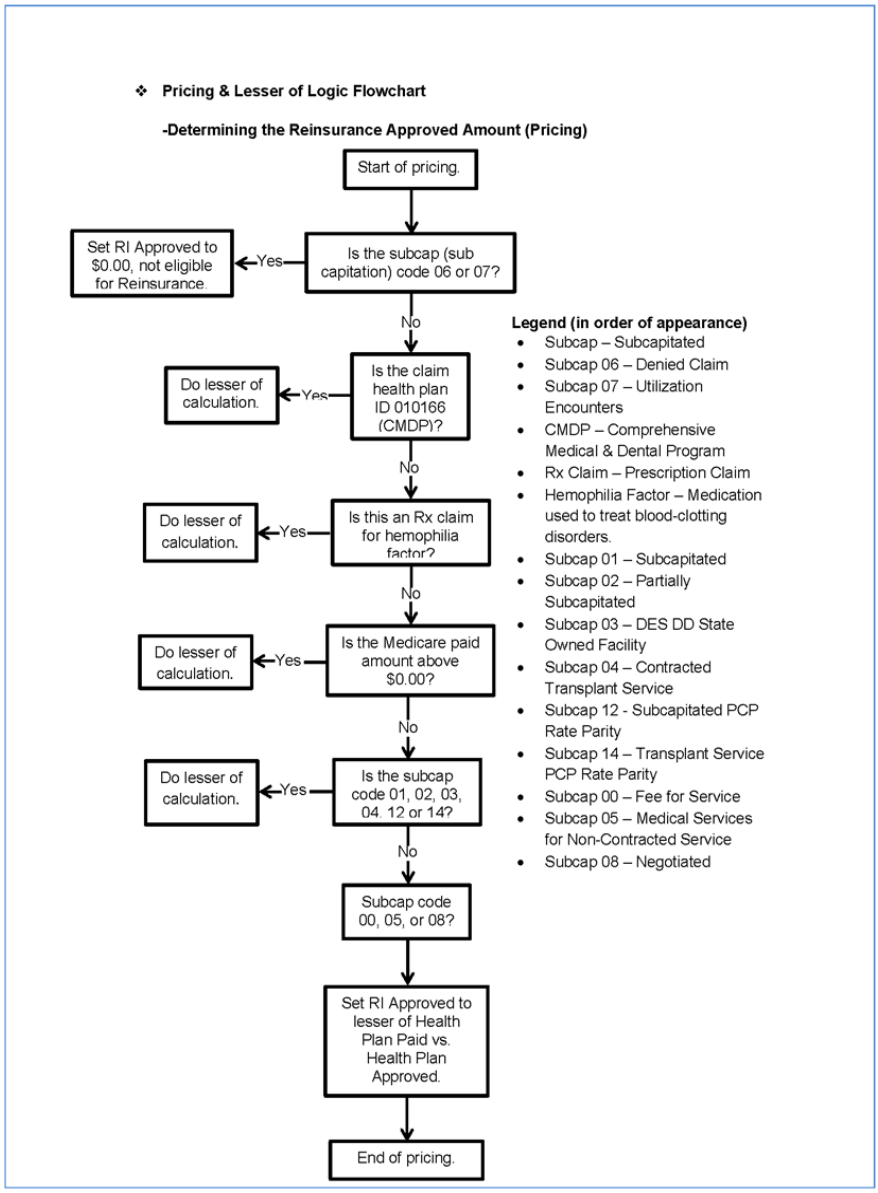
RI91L100 - Reinsurance Case Initiation Report

This report is a summary of Case information created during the previous month’s Reinsurance Case creation cycle including Encounter information for those Encounters associated to the Cases created in the reporting period.

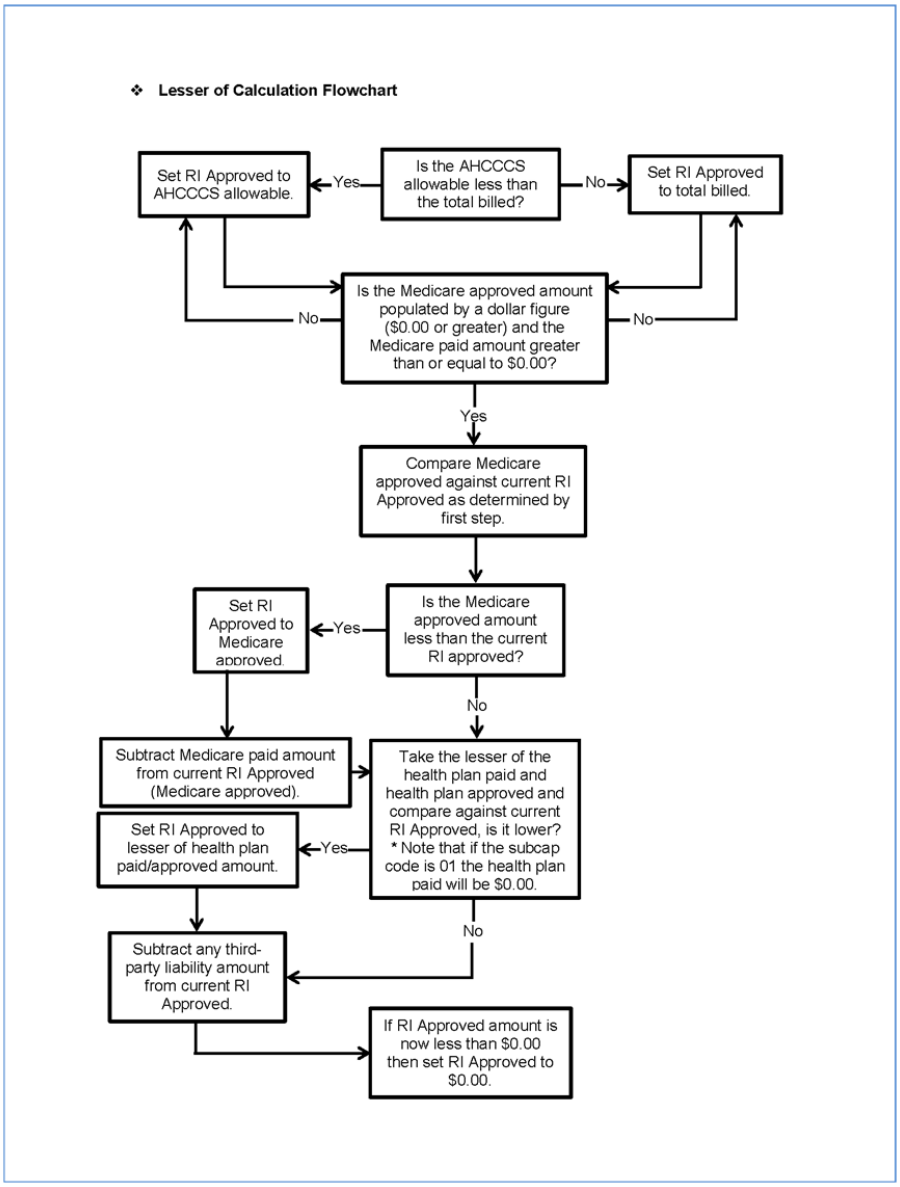
RI91L315 - Reinsurance Case Reconciliation Report

This report is a summary of Case information with a detailed listing of Encounters that potentially apply to an active Reinsurance Case but have not been associated to the Case due to pend errors. Also included are those Encounters in the edit/audit process to enable reconciliation of the Encounter records with the Reinsurance records.

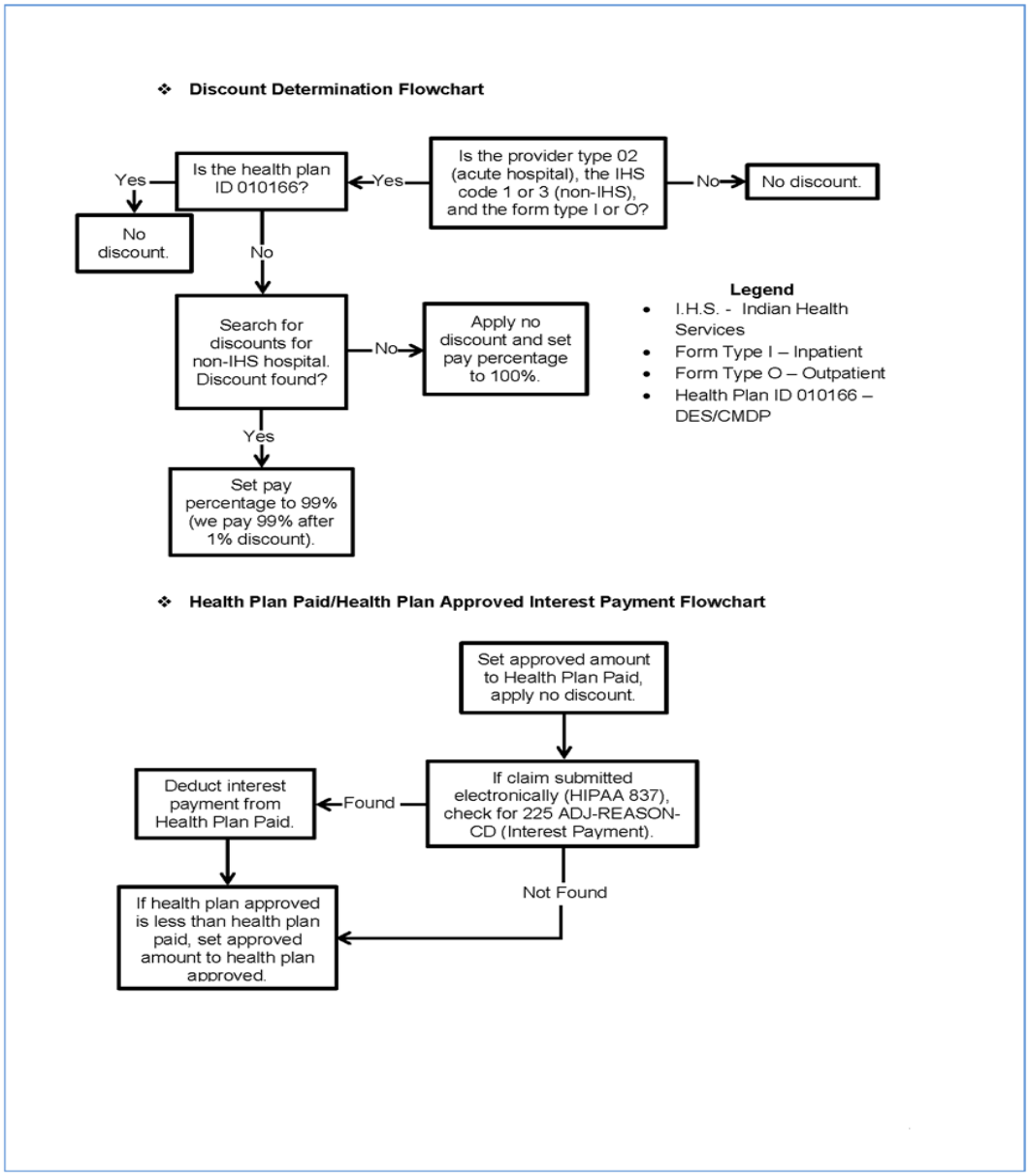
PRICING & LESSER OF LOGIC FLOWCHART



LESSER OF CALCULATION FLOWCHART



DISCOUNT DETERMINATION FLOWCHART



210 WORKING WITH THE BIRTH THROUGH FIVE POPULATION

EFFECTIVE DATE: May 4, 2022

REFERENCES: A.R.S. §13-3620, A.A.C. R9-20-205, Division Medical Chapter 200,

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and the system of care for behavioral health services for ALTCS eligible members whose contract includes this service. It is designed to strengthen the capacity of Arizona's Behavioral Health System in response to the unique needs of children age birth through five and emphasizes early intervention using clinical assessment, service planning and treatment, all of which focus on identification of situations that may potentially impede infants'/toddlers' ability to:

1. Form close parent/caregiver relationships with those in the child's environment (these may be long term or temporary, familial, or non-familial),
2. Experience, regulate and express their emotions, and
3. Explore their environment in an accessible manner.

DEFINITIONS

Assessment (Behavioral Health) means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or responsible person, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety or the Division of Developmental Disabilities. The size, scope, and intensity of

involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the AdSS, their subcontracted network, and provider agency the AdSS, their subcontracted network, and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, support coordination, and other clinical services. This may also include supervising staff that provide service delivery to children age birth through five and their families.

B. TARGET POPULATION(S)

All Division members birth through five years of age (up to age six), who are ALTCS eligible and are receiving behavioral health services, in collaboration with their caregivers.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

The promotion of behavioral health in infants and toddlers is critical to the prevention and mitigation of mental disorders throughout the lifespan. Over the past decade, the research has demonstrated mounting evidence pointing to the detrimental impact that early, negative childhood experiences can have on the developing brain. A well-known example of that research is a study conducted by a California Health Maintenance Organization. This longitudinal study, known as the ACES study (Adverse Early Childhood Experiences), showed a positive correlation between frequency of negative early childhood events (e.g., neglect, violence, trauma) and development of physical and behavioral health challenges in

adulthood. The more negative events that occurred during early childhood, the more adults tended to have physical and behavioral health conditions in adulthood such as depression, alcoholism, obesity, and heart disease. Although the ACES study points to the negative impact of adverse early childhood experience, the field of infant behavioral health has promulgated the knowledge in intervention techniques designed to mitigate negative effects of early abuse, trauma, or violence.

Early childhood experiences can build strong foundations or fragile ones and can affect the way children react and respond to the world around them for the rest of their lives. The early social and emotional development of infants and toddlers is vulnerable to factors, such as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance exposure. Without intervention, these risk factors can result in behavioral health disorders including depression, attachment disorders, and traumatic stress disorders, which can have an effect on later school performance and daily life functioning.

Children who have been maltreated are at an increased risk for behavioral health concerns, poor psychological adaptation and lifelong health difficulties. Children entering the child welfare system have higher rates of exposure to traumatic events with most victims of child abuse and neglect being under the age of five. Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of trauma.

1. An effective approach to promoting healthy social and emotional development shall include equal attention to the full continuum of behavioral health services including promotion, prevention, and treatment, plus improvement in system capacity for effective service delivery. Essential components of a comprehensive system include:

    a. Supporting the use of evidence-based early childhood service delivery models,

b. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals, and

c. Improving access to services.

Untreated behavioral health disorders can have disastrous effects on children's functioning and future outcomes. Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma. Behavioral Health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth, and constipation, as well as overall delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdrawal from social interaction.

Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) can predict subsequent aggressive behavior. Some early behavioral health disorders have lasting effects and may appear to be precursors of behavioral health problems later in life. Early signs and symptoms of behavioral health disorders may include withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and trauma stress reactions.

Increasingly, young children are being expelled from childcare and preschool for behavior problems, including biting, tantrums, hitting, throwing objects, or inconsolable crying. Even if they do remain in a program, young children with behavioral concerns are challenging to teach and quickly lose motivation for learning. Additionally, they may withdraw from their peers or face social rejection.

Healthy social-emotional development is strongly linked to success in elementary school. Children who are not secure in relating to others and do not trust adults are not motivated to learn. Furthermore, children who are unable to respond to calming influences initiated by themselves or others will not be responsive to teaching methods or benefit from their early

educational experiences and may lag behind their peers.

2. Parent's behavioral health can affect young children. Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond as parents with an untreated mental disorder are less able to provide developmentally- appropriate stimulation and parent-child interactions. Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence, and maltreatment. Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school. Although these sources cite maternal depression as a factor, these effects can also be attributed to relationships the young child has with other primary caregiver(s).

   Increased training in early childhood behavioral health is necessary and essential. In-depth knowledge of child development systems and multi-disciplinary approaches, as well as possession of diagnostic and clinical skills are critical components for professionals who assess and treat young children. Additionally, practitioners need to acquire and demonstrate a range of interpersonal skills in their work in order to build individualized, respectful, responsive, and supportive relationships with families. These skills include:

   a. The ability to listen and observe carefully,

   b. Demonstrate concern and empathy,

   c. Promote reflection,

   d. Observe and highlight the child-parent/caregiver relationship,

   e. Respond thoughtfully during emotionally intense interactions, and

   f. Understand, regulate, and use one's own feelings.

   Scientific advances in neurobiology have provided birth through five

practitioners with greater insight into the complex system of the brain. The development of the central nervous system begins with the formation of the neural tube, which nears completion by three to four weeks of gestation and is the basis for all further nervous system development. Genes determine when specific brain circuits are formed, and each child's experiences then shape how that formation develops. Stable and responsive relationships along with proper sensory input through hearing and vision are what build healthy "brain architecture." Thus, the most important relationships begin with the child's family and extend outward to other adults important in that child's life such as day care and educational providers.

3. Empirical evidence has shown that young children are greatly impacted by their early development and experiences. By understanding how specific events impact a young child's brain function, the behavioral health professional is able to formulate individualized interventions. Therefore, it is incumbent upon all practitioners to become educated about brain development, functions of various parts of the brain and their role in the physical and emotional development of the child. Some additional resources in the area of brain development include:

   a. "Brain Facts, A Primer on the Brain and Nervous System" through the Society for Neuroscience,

   b. "Starting Smart—How Early Experiences Affect Brain Development,"

   c. "From Neurons to Neighborhoods: The Science of Early Childhood Development," and

   d. C.H. Zeanah, Jr., (Ed.). (2009). Handbook of Infant Toddler Behavioral Health.

D. METHODOLOGY

In an ongoing effort to improve the delivery of behavioral health services in an effective and recovery-oriented fashion, the Arizona Vision, as established by the Jason K. Settlement Agreement in 2001, implemented the use of the Child and Family Team (CFT) practice model and the 12 Arizona Principles, both of which strongly support the critical components of behavioral health practice with children

birth through five and their families. Infant and Early Childhood Behavioral Health practice integrates all aspects of child development such as organic factors (genetics and health) with the child's experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

The nature and pace of these changes, as well as the preverbal nature of this young population present the behavioral health professionals with uniquely complex challenges. It is crucial for children to rely on the knowledge of the parents/ caregivers and the expertise of a multidisciplinary team of professionals to provide them with information when conducting behavioral health evaluations, developing service plans, and implementing clinical interventions. Qualified professionals shall have an understanding of the correct use and interpretation of screening, assessment, and evaluation tools and processes, plus how to use these results for service planning and implementing clinical interventions.

1. Assessment and treatment of children age birth through five is based on the philosophical orientation that work is done on behalf of the child, predominantly through the child's parent or caregiver(s). Child development takes place within the context of the caregiving relationship, which is strongly influenced by child characteristics, parent/caregiver characteristics, and perhaps most importantly the unique match or "fit" between a child and the child's caregivers. It is important that trained personnel:

    a. Have comprehensive knowledge of early childhood development,

    b. Possess excellent observational and relationship-building skills with children and adults,

    c. Be able to identify resources and needs within the family/caregiving environment, and

    d. Communicate assessment results in a comprehensible and accessible manner to parents/primary caregivers and other professionals.

2. For children who are ALTCS eligible and are under the custody of Department of Child Safety (DCS) and are being served by an AdSS who are referred through the Rapid Response process, it is important for the behavioral health

provider to consider a full range of services at the time of removal. Multiple AdSS policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:

a. AdSS Operations Policy 417,

b. AdSS Operations Policy 449,

c. AdSS Medical Policy 310-B,

d. AdSS Medical Policy 320-O, and

e. AdSS Medical Policy 541.

As part of the assessment process, ongoing evaluation of the child after the initial removal is needed to assess the child's physical appearance, areas of functioning, the child's relationships, and adjustment to the new environment. If the child is placed with a different caregiver, re-assess again to monitor the child's adjustment to the new setting. When assessing children involved with DCS who are showing delays which can be due to the trauma of removal, neglect, or abuse, determine if a referral for additional trauma informed care services or any other type of assistance is needed. Refer to AMPM 210 Attachment A for use with children living in a kinship placement, DCS resource parents (foster or adoptive), or congregate care (shelter or group home). Additional information outlining special considerations for providing services to infants, toddlers and preschool-aged children involved in the child welfare system can be accessed through: "The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS" (refer to AMPM Behavioral Health Practice Tool 260).

II. ESSENTIAL PROCESSES FOR ASSESSMENT, SCREENING AND SERVICE PLANNING

Evaluation practices with respect to children age birth through five involve awareness on the part of the behavioral health practitioner that all children have their own individual developmental progression, affective, cognitive, language, motor, sensory and interactive patterns. All children age birth through five are participants in relationships, with the child's most significant relationships being

those with their primary caregiver(s). A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of the child's most significant relationships. This is best done over several sessions, in different settings (e.g., home, childcare, clinic), and whenever possible with all significant caregivers. In order to support a child in demonstrating the child's true capacities, screening and assessment processes are most effectively offered in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and that reflect their daily life experiences. Identification of all significant caregivers and the child's relationship with each individual is a critical part of assessment practice.

A. DEVELOPMENTAL SCREENING

Division eligible children undergo developmental screening prior to enrollment with the Division. Refer to AdSS Medical Policies 430 and 541 for details. In addition, when a child aged birth to five is receiving behavioral health services, screening for sensory, behavioral, and developmental concerns continues as an ongoing process that organizes continuous observations regarding the needs, challenges, strengths and abilities of the child and parent/caregiver. Screening or testing instruments become part of comprehensive assessment practice, are intended to be used for the specified purpose they were designed for, shall be reliable and valid, and are not to be used in isolation to render a diagnosis.

The use of AMPM 210 Attachment B provides assessors and caregivers with a set of dimensional milestones (e.g., movement, visual, hearing, smell, touch, speech, social and emotional, language, cognitive, hand and finger skills), as well as growth and developmental "red flags". As part of the assessment process for infants and young children, developmental checklists establish a baseline to which subsequent screenings during the course of treatment can be compared. Developmental checklists provide opportunities to assess the degree to which children are meeting developmental milestones. Should there be delays in meeting standard developmental milestones, it may be necessary to refer to the child's PCP for further evaluation. For children three to five, a referral to the public school system may be more appropriate. The various professionals supporting the child and family shall

plan and communicate to avoid duplication of screening services. Multiple developmental screening tools are available. Some are suggested directly within this document and others are provided as attachments to AMPM 210. These tools are available as accompaniments to this Practice.

B. ASSESSMENT CONSIDERATIONS

It is essential that behavioral health practitioners continually evaluate their screening and assessment tools because the practice of infant and early childhood behavioral health is dynamic and continually changes due to improved technology and newly developed research techniques, strategies, and results. While the Division does not require the use of a specific assessment tool, minimum elements have been established that shall be included in any comprehensive behavioral health assessment as specified in AdSS Medical Policy 320-O. Refer to AMPM 210 Attachment C, as one example of an assessment tool for children age birth through five. Additional options for assessments specific to children birth through five, are included as AMPM 210 attachments.

1. There is no single tool that encompasses the full range of social, emotional, and developmental skills and challenges that can occur in young children. The following tools and resources can provide additional information when assessing developmental milestones, behavioral, emotional, and social concerns, trauma and attachment:

    a. Ages and Stages Questionnaire (ASQ): developmental and social-emotional screening for children aged one month to five and ½ years,

    b. Hawaii Early Learning Profile (HELP): curriculum-based assessment covering regulatory/sensory organization, cognitive, language, gross and fine motor, social and self-help areas for children birth to three years, separate profile available for three- to six-year-old children,

    c. Infant-Toddler Social-Emotional Assessment (ITSEA©): measures social-emotional and behavioral domains for children one to three years of age,

d. Connor's Early Childhood Assessment: aids in the early identification of behavioral, social, and emotional concerns and achievement of developmental milestones for children two to six years of age,

e. Parents' Evaluation of Developmental Status (PEDS): evidence-based screening of developmental and behavioral concerns for children birth to eight years, and

f. Trauma-Attachment Belief Scales (TABS™): measure cognitive beliefs about self and others for parents/caregivers aged 17 and older to assist with identifying possible trauma history and its potential impact on the attachment relationship between the parent/caregiver and the child.

Considerable skill is required in the administration of the assessment process, integration of the data obtained from the assessment, and development of initial clinical conceptualizations and intervention recommendations. Refer to Technical Assistance Paper No. 4, "Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs" for further information on other resources and test reviews of screening and assessment instruments.

Assessment with children age birth through five is a specialty area that requires specific competencies. Competent providers recognize the limitations of their knowledge and scope of practice. When necessary, they make use of the expertise of more experienced behavioral health practitioners, as well as the range of disciplines that address questions related to early development (e.g., pediatrics, speech/language therapy, occupational therapy, physical therapy) through collaboration, consultation, and referral practices.

2. Behavioral Health Assessment practice with children age birth through five typically involves:

a. Interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories,

b. Direct observation of family functioning,

c. Gaining information, through direct observation and report, about the child's individual characteristics, language, cognition, and affective expression,

d. Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,

e. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/learning, and to help regulate emotions,

f. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship, and

g. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, behavioral health, parenting, legal, educational, domestic violence, military).

AdSS Medical Policy 310-B and 320-O provide additional information on the types of behavioral health providers that may conduct assessments.

C. DIAGNOSTIC CONSIDERATIONS

The diagnostic process consists of two aspects: the classification of disorders and the assessment of individuals. In classifying disorders, practitioners are able to communicate with one another about descriptive syndromes using universal terms and language. The diagnostic process is ongoing rather than a one time "snapshot" of symptoms. Behavioral Health practitioners collect information over time in order to understand multiple aspects of the presenting concerns, as well as variations in adaptation and development that are revealed on different occasions within various contexts.

It is suggested that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the Diagnostic Classification of Behavioral Health and Developmental Disorders in Infancy and Early Childhood (DC:

0-5). This diagnostic manual, which draws on empirical research and clinical practice that has occurred worldwide since the manual was first published in 1994 as the DC: 0-3 and revised in 2016. The DC: 0-5 is designed to help behavioral health and other professionals recognize behavioral health and developmental challenges in young children, understand how relationships and environmental factors contribute to behavioral health and developmental disorders, use diagnostic criteria effectively for classification and intervention, and work more effectively with parents and other professionals to develop effective service plans. The updated version provides clear and specific criteria for all diagnostic categories. Examples include:

1. Criteria for identifying autism spectrum disorders in children as young as 2, introduces.
2. New criteria for disorders of sleep, eating, relating, and communicating.
3. Clarifies the Parent-Infant Relationship Global Assessment Scale (PIRGAS).
4. Checklists for identifying relationship problems, psychosocial and environmental stressors.

Copies of the DC: 0-5 manual are available through the Zero to Three Press. This manual contains the DC: 0-5 codes that correspond to DSM-5 codes, as well as the ICD-10 codes.

For Division eligibility criteria refer to the Division Eligibility Policy Manual.

D. ANNUAL ASSESSMENT UPDATE

While assessment is an ongoing process that offers new information throughout the continuum of service delivery, a formal assessment update shall be completed on an annual basis, or sooner, if there has been a significant change in the child's/family's status. A child's response to treatment might be affected by significant events or trauma that have occurred since the last assessment/update, such as changes in the child's living environment, childcare arrangements, death of a primary caregiver, as well as medical/developmental conditions and hospitalizations. Input from the family/ caregiver, as well as observation(s) of the child in conjunction with a review of the clinical record, provides the information necessary for summarizing their response to treatment and progress toward meeting goals over the past year.

A review of the child's current level of functioning would include updating information related to the child's emotional and behavioral regulation, quality of the parent-child interaction, relationships with caregivers/significant others, living environment, family stressors, safety concerns, and stability of home/relationships. Developmental screening as part of the annual update, and during the course of treatment, will assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral.

E. SERVICE PLANNING CONSIDERATIONS

1. Use of CFT Practice

The early development of an engaged relationship with the child, parent/ caregiver, and family as part of the CFT process, is required practice when working with children age birth through five. This critical work directly involves the entire family, and it is the family that guides the therapeutic process. Refer to the Child and Family Team Practice Tool on the AHCCCS website under Guides - Manuals – Policies AMPM Chapter 200. This Practice Tool provides additional information on the specific components and the required service expectations of this practice model.

Infants and young children benefit from planning processes that support the inclusion of the following components:

a. Ongoing and nurturing relationships with one or two deeply attached individuals,

b. Physical protection, safety, and regulation at all times,

c. Experiences suited to individual differences to include regular one-to-one interaction between the caregiver and child,

d. Developmentally appropriate experiences (e.g., one-to-one interaction that encourages an emotional dialogue that fosters a sense of self, problem solving, communication skills and a sense of purpose),

e. Limit setting, structure, and expectations (e.g., clear messages and routines), and

f. Stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral concerns and/or developmental delays. An essential part of the therapeutic process is to help reduce this social isolation. Encouraging the exploration of natural supports can spur a family to begin thinking differently about their support system(s).

Whenever possible, the utilization of natural environments for clinical intervention is recommended. If the natural environment is not a conducive setting due to a lack of privacy, site of traumatic event for the child/parent and/or safety concerns, alternative settings need to be considered with input from the family. In addition to location, natural environments also include the everyday routines, relationships, activities, people and places in the lives of the child and family. health, right, and safeguards

2. Community Collaboration

Starting with the assessment process, intervention strategies incorporate information from all involved providers serving the child, parent, or caregiver. This may include healthcare, childcare, and early intervention providers, the parent's/caregiver's behavioral health provider(s), as well as friends and extended family that are important in the family's life. Examples of several early intervention providers include Head Start/Early Head Start, the Arizona Early Intervention Program, Early Childhood Education through the Arizona Department of Education, and the Division of Developmental Disabilities. These individuals, if the parent/caregiver wishes, then become part of the Child and Family Team who will develop an effective service plan that employs natural supports in conjunction with formalized services. The size, scope and intensity of team member involvement are determined by the objectives established for the child and needs of the family in providing for the child.

In order to make informed referrals as part of the service planning process it is imperative that behavioral health professionals and technicians (BHPs & BHTs) who work with children age birth through five and their families, become familiar with community services and programs that serve young children, as well as the local school district programs for children three to five years of age. At minimum, BHPs and BHTs should have familiarity with AzEIP, Head Start, Division of Developmental Disabilities, ADHS Office of Children with Special Health Care Needs, First Things First, and school district services that may be available for children eligible for preschool.

If at any time throughout the assessment, treatment delivery, or service planning processes a behavioral health practitioner believes that a child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a duty to report that belief to a peace officer or DCS per A.R.S. §13-3620. Behavioral Health staff is to consult with their supervisor if they are unclear about their duty to report a situation.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication, and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For non-enrolled children who are not Medicaid eligible, coordination and communication should occur with any known health care provider. Refer to AdSS Medical Policy 211 for additional information on the use and coordination of psychotherapeutic and psychopharmacological interventions.

Documentation in the clinical record is required to show the communication and coordination of care efforts with the health care provider related to the child's behavioral health treatment (refer to AdSS Medical Policy 320-O and 940).

F. SERVICE PLAN DEVELOPMENT

1. While a comprehensive and accurate assessment forms the foundation for

effective service planning and is required before a service plan can be fully developed, needed services should not be delayed while the initial assessment process is being completed. In addition to consideration of clinical disorders, findings from a comprehensive assessment of children birth through five years of age should lead to preliminary ideas about:

a. The nature of the child's pattern of strengths and difficulties, risk, and protective factors,

b. Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,

c. Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns, etc. to the child's competencies and difficulties, and

d. How the service planning process will address these areas.

Service plans should be strength-based in addressing needs and whenever possible draw upon natural supports. For young children, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.

A comprehensive and intensive approach to service planning would include attention to those factors that place young children's healthy attachment and social-emotional development at risk. Critical planning includes interventions that address a parent's/caregiver's behavioral health concerns and how these may affect the ability of that parent/caregiver to interact with and respond sensitively to the child's emotional and physical needs. Prematurity, low birth weight and conditions associated with prenatal substance exposure may require specific interventions when they affect the early social and emotional development of infants and toddlers.

Service planning also needs to address a child's ability to form close parent/

caregiver relationships. These relationships can be undermined by traumatic events such as repeated exposure to violence, abuse, or neglect, or when children experience multiple caregiver changes. When the child/family has multi-agency involvement, every effort should be made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. Additionally, planning should address collaboration with early intervention service providers and early education programs. This is especially important for those children who are experiencing expulsion from childcare or preschool settings due to behavioral concerns.

The use of all service settings, the full array of covered services, and skilled, experienced providers are to be considered as identified by the Child and Family Team during the service planning process. Service planning that includes the use of Support and Rehabilitative Services is often an essential part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community (refer to AMPM 230).

All service plan development with children age birth through five is completed collaboratively with the child's parent or primary caregiver. Development and prioritization of service plan goals are not focused solely on the child. It is essential to include the parent, caregiver, and the needs of the family as a whole. Due to the age of the birth through five population and the rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives. At the time of the Annual Update, the service plan should be modified to align with the needs identified in the updated Assessment. Refer to AdSS Medical Policy 320-O for further information on the minimum elements for Assessments, Service Plans, and required timeframes for completion.

2. Clinical Practice

The guiding principle in the practice of infant and early childhood behavioral health is to "do no harm." Clinical intervention assumes a preventative, early

intervention treatment focus based on sound clinical practice, delivered in a timely and accessible manner across all settings, and implementation in accordance with the Arizona Vision and 12 Principles. Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.

a. Infant and early childhood therapeutic approaches are supported by the following conceptual premises:

   i. The child's attachment relationships are the main organizer of the child's responses to danger and safety in the first five years of life,

   ii. Emotional and behavioral problems in early childhood are best addressed within the context of the child's primary attachment relationships, and

   iii. Promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.

b. The following skills and strategies are fundamental to the work of infant and early childhood behavioral health:

   i. Building relationships and using them as instruments of change,

   ii. Meeting with the infant and parent/caregiver together throughout the period of intervention,

   iii. Sharing in the observation of the infant's growth and development,

   iv. Offering anticipatory guidance to the parent/caregiver that is specific to the infant,

   v. Alerting the parent/caregiver to the infant's individual accomplishments and needs,

   vi. Helping the parent/caregiver to find pleasure in the

relationship with the infant,

vii. Creating opportunities for interaction and communication exchange between parent/caregiver(s) and infant or parent/caregiver(s) and practitioner,

viii. Allowing the parent/caregiver to take the lead in interacting with the infant or determining the agenda or topic for discussion,

ix. Identifying and enhancing the capacities that each parent/caregiver brings to the care of the infant,

x. Wondering about the parent/caregiver's thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood.

xi. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent,

xii. Listening/observing for the past as it is expressed in the present, inquiring, and talking,

xiii. Allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing, and talking about them as the parent is able,

xiv. Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant's development, the parent/caregiver's emotional health and the early developing relationship,

xv. Attending and responding to the infant's history and early care within the developing parent/caregiver-infant relationship,

xvi. Identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness and family dysfunction,

and

xvii. Remaining open, curious and reflective.

While all the skills and strategies noted above are pertinent in working with children and families, item “xi” through “xvii” are of unique importance to the practice of the infant and early childhood behavioral health practitioner. These seven strategies address the emotional health and development of both the parent/caregiver and the child. The practitioner focuses on past and present relationships and the complexities many parents/caregivers encounter when nurturing, protecting, and responding to the emotional needs of their children. Within this context, the practitioner and parent/caregiver may think deeply about the care of the young child, the emotional health of the parent/caregiver, the many challenges of early parenthood, and the possibilities for growth and change.

3. Clinical Approaches

Information obtained through the assessment process will guide infant and early childhood trained practitioners in determining which intervention(s) is most conducive in meeting the needs of the young child and the child’s family. More than one approach may be utilized and integrated into the service plan.

Support is the most basic intervention, where behavioral health personnel function as a resource to assist primary caregivers in accessing community resources, such as housing, employment, childcare, health services and food. Emotional support may also be provided to families when they are faced with a crisis related to the care of their child(ren). This support can be shown by the clinician’s attention to the expressed concerns of the caregiver, acknowledgement of the caregiver’s needs and strengths, and showing empathy in response to the situation. Support and Rehabilitation services can also assist with reducing the family’s distress so that they are able to focus on the care requirements of their young child.

Advocacy can take the form of helping caregivers in expressing their needs

and navigating systems of care. It can be challenging for clinicians to know when and how to speak effectively on behalf of young children and their families, especially those who may be involved with the child welfare system.

Developmental Guidance provides information to the primary caregiver(s) on a young child's abilities, developmental milestones and needs, as well as practical caretaking guidance that may be delivered individually or in a group format. Within the therapeutic environment, the clinician can offer opportunities to the caregiver to enhance positive interaction and playful exchange with the child. These exchanges, if based on the child's developmental needs, reinforce what the caregiver is able to do with the child and may promote a mutually pleasurable experience and purposeful response at the child/caregiver relationship level.

Relational Guidance helps primary caregivers to increase their knowledge of and experience with their infant or young child through spontaneous interactions. Caregivers are taught how to attend to their child's distinctive cues with clinicians modeling parenting behavior. When using guided interaction strategies, clinicians can then provide feedback directly or review videotapes with the caregiver.

The following two approaches to therapy focus on the relationship between the primary caregiver and the infant. *Child-parent psychotherapy* offers the opportunity for thoughtful exploration with the caregiver of the child's ideas about parenthood and the continuing needs of the infant or toddler. The clinician assists the primary caregiver in gaining access to repressed early experiences, re-examining the feelings associated with them and achieving insight into how these experiences may affect the caregiver's capacity to be responsive to the infant. Relational difficulties with the infant may take the form of a caregiver's inability to hold or feed their baby, set limits that are appropriate in keeping young children safe, or interacting and communicating in ways that will arouse the child's curiosity. The infant is included as a catalyst for change, with the clinician guiding the caregiver to interact in a different way with their infant. A second approach, *child-parent dyadic*

therapy, reflects the perspective that infants contribute to relationships and holds that the infant is able to use the time therapeutically for him/herself, similarly to the caregiver.

Attachment theory based in part on John Bowlby's *internal working model*, proposes that early experiences with the parent or primary caregiver forms the basis of memory patterns or "internal working models" that influence behaviors for other social relationships. Interventions are consistent with attachment theory if they include the following elements:

a. Provide emotional and physical access to the mother/caregiver,

b. Focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals,

c. Place the mother/caregiver in a non-intrusive stance,

d. Provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver, and

e. Provide a clinician who functions as a secure base for the dyad.

Developmental approaches to therapy offer an alternative to the traditional behavioral approach. Modalities under this approach can provide a framework for understanding and organizing assessment and intervention strategies when working with children with developmental delays and behavioral health concerns.

Reference materials on infant and early childhood mental health practice have been provided as a supplemental resource. This resource list is not meant to be exhaustive, given that research and clinical practice in this area continue to evolve.

G. TRAINING AND SUPERVISION RECOMMENDATIONS

Behavioral Health over the past several decades, has experienced significant advances in the understanding of early child development and the effects of trauma on early brain development. The need to have providers with trained expertise in this area has risen dramatically and is well recognized nationally and in Arizona. AHCCCS

is focused on efforts in several areas to build workforce expertise and availability of services to children age birth through five and their families.

H. WORKFORCE DEVELOPMENT

The Infant and Toddler Behavioral Health Coalition of Arizona (ITMHCA) has adopted the Michigan Association for Infant Behavioral Health Endorsement® for Culturally Sensitive, Relationship-Based Practice Promoting Infant Behavioral Health. Endorsement® recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family field. This endorsement® model describes the areas of expertise, responsibilities, and behaviors that demonstrate competency and verifies that professionals have attained a specified level of understanding and functioning linked to the promotion of infant behavioral health. Of additional importance, endorsement provides an organized approach to workforce development that identifies competency- based trainings and reflective supervision experiences that enhance confidence and credibility among infant, toddler and family clinicians (Behavioral Health Professionals), as well as other professionals who work with this population (Behavioral Health Technicians/Behavioral Health Paraprofessionals). While competency-based training and reflective supervision supports behavioral health practitioners who work primarily with young children and their families, this expertise may also be applied to professionals working with adults with a serious mental illness or substance use concerns who are parenting their own infants/toddlers.

It is recommended that provider agencies have practitioners endorsed as appropriate to the mission of the agency. Endorsement® through the ITMHCA includes four levels of competency:

1. Level 1: Infant Family Associate - Individuals who possess Child Development Associate (CDA), or academic degree, or two years of infant and early childhood related paid work experience; recommended for childcare or respite workers.

2. Level 2: Infant Family Specialist - Bachelor's, Master's or Doctoral (e.g. Social Work, "Applied" studies, nursing, behavioral health related) degree and a minimum of two years' work related experience with infants/toddlers and

families; recommended for behavioral health staff involved in service planning and delivery such as case management and peer/family support, support and rehabilitation service provider personnel, parent educators, childcare consultants, and DCS workers.

3. Level 3: Infant Behavioral Health Specialist - Masters, MSN (Nursing), PhD, PsyD, EdD, M.D. or D.O. with two years post-graduate work and training in infant, early childhood, and family fields; recommended for behavioral health clinicians and supervisors, infant behavioral health specialists, clinical nurse practitioners, psychologists, and early intervention specialists. Reflective Supervision is required.

4. Level 4: Infant Behavioral Health Mentor - (Clinical, Policy, or Research/ Faculty) Individuals at the mastery level (Master's, Postgraduate, Doctorate, Post Doctorate, MD or DO) qualified to train other professionals; recommended for infant and early childhood program supervisors, administrators, policy specialists, and physicians/psychiatrists.

Endorsement information and application materials are available through the local Infant Toddler Behavioral Health website: Infant Toddler Behavioral Health Coalition of Arizona (www.itmhca.org).

I. TRAINING

This Practice Tool applies to the AdSS and their subcontracted network and provider agencies, including the behavioral health staff that provide direct service delivery to children age birth through five and their families. Behavioral health practitioners working with this population (children age birth through five) require specialized training. Professional development in the area of infant and early childhood behavioral health is necessary at all levels of the Behavioral Health System, along with the personnel of service systems that interface with behavioral health professionals, such as DCS, the Division, AzEIP, and other community-based early intervention programs.

Behavioral Health practitioners seeking increased knowledge in this area are encouraged to attend infant and early childhood behavioral health trainings that

include:

1. A multidisciplinary approach that is strengths-based.
2. Effective interviewing, communicating and observational techniques.
3. Assessment of parent-infant relationships.
4. Screening and diagnostic measures for infants and toddlers.
5. Early childhood development.
6. Effects of early adverse experiences and trauma.
7. Understanding parent-child interactions and healthy attachment.
8. Cultural influences in parenting and family development.
9. Building a therapeutic alliance.
10. Treatment and intervention strategies/modalities endorsed by AHCCCS.
11. Collaboration practices with other providers/caregivers.
12. A reflective practice focus.

It is the expectation of the Division that behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth through five and their families, be well trained and clinically supervised in the application of this tool. Each AdSS shall establish their own process for ensuring that all agency clinical and support services staff working with this population understand the recommended processes and procedures contained in this tool. Whenever this Practice Tool is updated or revised, each AdSS ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

J. SUPERVISION

Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R9-20-205 Clinical Supervision requirements.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development (different from administrative or clinical supervision) that focuses attention on supporting the growth of relationships that is critical to effective infant and early childhood behavioral health practice. How each of these relationships interrelates and influences the others is explored through reflective supervision and is referred to as the "parallel process".

1. Relationship between supervisor and practitioner.
2. Relationship between practitioner, parent/caregiver/child.
3. Relationship between parent/caregiver/child.
4. Relationship between all of the above.

In each of these relationships there is an emphasis on learning, personal growth, and empathy. Through this process, supervisors assist practitioners in professional skill development and ensure that practitioners are maintaining the agency's standards for clinical performance.

Key elements of reflective supervision include reflection, collaboration, and consistency. With supervisory support, the practitioner reflects on the emotional content of the work and how one's reaction to this content affects their work. Supervisors support a practitioner's professional development through the acquisition of new knowledge by encouraging the supervisee to assess their own performance. The supervisor's ability to listen and wait allows the practitioner an opportunity to analyze their own work and its implications, and to discover solutions, concepts or perceptions on one's own, without interruption. Collaborative supervision is characterized by the development of a trusting relationship between the supervisor and practitioner in which both parties can safely communicate ideas and share responsibility for decision-making without fear of judgment. Establishment of a consistent and predictable schedule of supervisory sessions supports the professional development of infant and early childhood behavioral health practitioners.

It is the recommendation of the Division that personnel who supervise staff providing service delivery to children age birth through five and their families, receive

adequate training in the elements of Reflective Practice and Supervision before implementing this approach in their supervisory activities. Criteria for provision of reflective practice is outlined on the Michigan Infant Toddler Behavioral Health website, but at minimum, Reflective Supervision requires Endorsement® for Infant Behavioral Health Specialist or Infant Behavioral Health Mentor with a minimum of 50 clock hours within a one-to-two-year timeframe. Additional information is also available within AMPM 210 Attachment E for additional resource materials on reflective supervision and consultative practices.

Training and supervision support the acquisition of specific knowledge, skills, and competencies critical to delivering effective relationship-based services to children age birth through five and their families. While training and other academic learning venues build the practitioner's understanding of core concepts, it is through supervision that practitioners can assess their level of competency when applying these concepts within their scope of practice. When evaluating a practitioner's level of knowledge as part of supervisory activities, supervisors can compare the skills of the clinician with Endorsement® Competency Guidelines and Requirements available on either the Arizona or Michigan Infant Toddler Behavioral Health websites. However, possession of similar knowledge and skills does **not** equate to actual Endorsement®, given the proprietary nature of the Endorsement® process (e.g., evidence-based training standards, testing, ethical standards).

K. ANTICIPATED OUTCOMES

1. Increased community and professional awareness of infant and early childhood behavioral health,

2. Improved use of effective screening, assessment, and service planning practices specific to the needs of children age birth through five and their families,

3. Increased knowledge and referrals to early intervention resources in the community, and

4. Improved outcomes using accepted approaches in working with children age birth through five and their caregivers.

L. DIVISION OVERSIGHT OF AdSS

The AdSS shall participate in the Division's oversight utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of each standard related to birth to age five, including but not limited to:

    a. Policies/procedures to ensure, and evidence of, appropriate high-need identification for the birth to five population.

    b. Policies/procedures to promote/increase availability of, and evidence of, availability of trained specialists (ITMHCA standards).

    c. Policies/procedures to ensure, and evidence of, staff training and supervision is completed as outlined in this policy.

    d. Ongoing monitoring of, and evidence of, adequate network capacity for children age birth to five.

2. Submit deliverable reports as required by the AdSS Contract with the Division.

3. Participate in Division oversight meetings for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and receiving direction or support from the Division as necessary.

4. Demonstrate ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:33 PDT)
Anthony Dekker, D.O.

211 PSYCHIATRIC AND PSYCHOTHERAPEUTIC BEST PRACTICES FOR CHILDREN BIRTH THROUGH FIVE YEARS OF AGE

EFFECTIVE DATE: May 4, 2022
REFERENCES: AMPM 211

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) for ALTCS eligible members whose contract includes this service. The policy establishes best practice processes and goals for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions for children birth through five years of age.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the AdSS, their subcontracted network and providers who furnish psychotherapeutic assessments and interventions, complete psychiatric evaluations, and prescribe psychopharmacological treatment for children birth through five years of age.

B. TARGET POPULATION(S)

The target population includes all members enrolled with the Division who are ALTCS eligible, receive behavioral health services through an AdSS, and are age birth through five (up to age six), in collaboration with their caregiver(s) and Child and Family Teams (CFT). This policy is also applicable when working with parents and/or caregivers who have children as described above, regardless of whether the child or parent(s) were referred or are seeking services.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

Psychiatric disorders presenting in young children are a public health concern, and

they can negatively impact normative developmental trajectories in all spheres, physical, social, emotional, and cognitive. One of the challenges in the field of behavioral health care for young children is the belief that young children cannot develop behavioral health disorders. Yet, these disorders if not recognized and appropriately diagnosed, may result in challenging behaviors, such as significant aggression toward others (e.g., biting, hitting, kicking) and emotional dysregulation (e.g., uncontrollable tantrums or crying). These behaviors, when not addressed, can result in serious consequences such as childcare expulsion, difficulty participating in family activities, and impaired peer relationships, making early intervention extremely important for families and caregivers that have young children with behavioral challenges.

Because of the complexities in treating infants and toddlers, the field of infant behavioral health has evolved to promote recognition of the rapid developmental processes and the importance of a healthy relationship between a secure child and the caregiver (either temporary or permanent caregiver for treatment purposes). Given the unique needs of infants and toddlers, numerous therapeutic interventions exist, summarized in a table (page 8), that can aid in reducing potentially damaging consequences. There is robust evidence supporting the use of relationship-based interventions, which focus on the child and parent/guardian/designated representative relationship. Generally, these treatment approaches focus on improving child and family/ guardian/designated representative functioning relative to the identified emotional and/or behavioral challenges and can often be successful without introduction of pharmacological intervention.

In the absence of marked or sustained improvement, it may be necessary to follow the appropriate steps toward psychotropic intervention. However, “Psychotropic medications are only one component of a comprehensive biopsychosocial treatment plan that shall include other components in addition to medication,” according to American Academy of Child and Adolescent Psychiatry.

It is critical to recognize that there are physical causes for behavioral health and developmental delays that may cause signs and symptoms which overlap with

behavioral and developmental concerns. It is therefore essential to first ensure that potential physical health issues have been ruled out. AdSS Medical Policy 430 provides guidance for standard screening and testing for lead poisoning, which includes blood testing whenever a concern arises that indicates a need for blood lead testing.

The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. While considering whether medication should be introduced in treatment, the benefits of the medication shall be evaluated and compared to the potential biological and psychosocial side effects. According to a 2007 set of Guidelines by the Preschool Psychological Working Group, little is known about the potential effects on neurodevelopmental processes in very young children when exposed to psychotropic medications. Research summaries indicate that younger children metabolize medications differently than older children. Moreover, a review of the current literature demonstrates that there is more evidence to support psychotherapeutic rather than psychopharmacologic interventions in young children presenting with psychiatric symptoms. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications. Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.

Due to the concerns outlined above, evidence of substantial increases in prescribing antipsychotics for children and increased federal and state attention toward prescribing practices, Arizona has recognized the need to implement revised initiatives for young children to address psychotropic medication use. As of May 2016, AHCCCS provided analysis and trending of current psychotropic prescribing practices, particularly for young children and children in the foster care system.

Data analysis for this report, revealed several key findings including:

- For Arizona in general, psychotropic prescribing rates in 2013 were higher for all foster children zero to 18, when compared to non-foster care children zero to 18.

- For Arizona, foster care children zero to six were prescribed psychotropics at a rate 4.6 times higher than non-foster care children zero to six in Arizona's Medicaid system.

Based on the AHCCCS May 2016 report and the recognition that, despite continued lack of consistent national guidelines, AHCCCS has reorganized the original practice guideline into five sections, which align with current process within Arizona. Additional revisions focus on updated research and findings with regard to psychotropic prescribing practices. Focus has been added to align with current Maternal Child Health/Early and Periodic Screening Diagnostic and Treatment (MCH/EPSDT) practice, plus Bright Futures. As such, the Guidelines within this document now comprise:

- Assessment by Behavioral Health Professional/Provider
- Psychotherapeutic Interventions
- Psychiatric Evaluation
- Psychopharmacological Interventions
- EPSDT: Assessing Physical and Behavioral Needs Through Developmental Surveillance, Anticipatory Guidance, and Social/Emotional Growth.

Refer to AdSS Medical Policy 210 for additional information on behavioral health screening, assessment, and treatment for children birth through five years of age.

D. ASSESSMENT BY BEHAVIORAL HEALTH PROFESSIONAL/PROVIDER

The initial assessment for a young child, at a minimum, consists of the following components as described in The American Academy for the Psychiatric Assessment of Infants and Toddlers (0-36 Months):

1. Gathering information from those individuals who are most familiar with the child, as well as direct observation of the child with their responsible person or caregiver, if directly involved with the child for treatment purposes (caregiver may be a family member or foster parent – either temporary or

permanent).

2. Reason for referral including the child's social, emotional, and behavioral symptoms.

3. Detailed medical and developmental history.

4. Current medical and developmental concerns and status.

5. Family, community, childcare, and cultural contexts which may influence a child's clinical presentation.

6. Parental and environmental stressors and supports.

7. Parent/guardian/designated representative perception of the child, ability to read/ respond to child's cues, and willingness to interact with the child.

8. Children's birth through five mental status exam:

    - Appearance and general presentation
    - Reaction to changes (e.g., new people, settings, situations)
    - Emotional and behavioral regulation
    - Motor function
    - Vocalizations/speech
    - Thought content/process
    - Affect and mood
    - Ability to play by self and with peers, explore
    - Cognitive functioning
    - Relatedness to parent/guardian/designated representative

9. Use of standardized instruments to identify baseline functioning and track progress over time. Examples of such instruments include, yet are not limited to the following:

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
INFANT TODDLER SOCIAL-EMOTIONAL ASSESSMENT (BITSEA)	*Social/Emotional* Brief report questionnaire focused on child symptomatology	12 to 36 mos. Multicultural	Professional or Parents/guardians/ designated representatives
BEHAVIORAL ASSESSMENT OF BABY'S EMOTIONAL AND SOCIAL STYLE (BABES)	*Behavioral Screening for temperament*, ability to self-soothe and regulate	Ages birth to 36 months	Parent/guardian/designated representative (for use in pediatric practices or early intervention programs)
CHILD BEHAVIOR CHECKLIST 1-5 (ASEBA) (ACHENBACH AND RESCORLA; 2001)	*Social/Emotional* Parent and teacher ratings, descriptions and concerns of child behaviors; Corresponds to DSM	Ages 1.5 years+ Multicultural	Professional Training required
PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA); (EGGER & ANGOLD, 2006)	Psychiatric diagnosis incorporating both DSM and DC:0-3R	Ages 2 to 5 years Boys/Girls Multicultural	Professional only Training required
CLINICAL PROBLEM-SOLVING PROCEDURE (CROWELL AND FLEISHMANN; 2000)	Structured observations of parent/child interactions	Ages 1 year to 5 years	Professional Videotaping essential
AGES AND STAGES QUESTIONNAIRE (ASQ-3)	Routine screening to assess developmental performance	Ages at various points from 1 month to 66 months; Boys & girls Multicultural	Parent completion
CONNOR'S EARLY CHILDHOOD ASSESSMENT	Measures specific patterns related to ADHD, cognitive and behavioral challenges	Ages 3 to 6+ Boys and Girls	Parent & teacher responses

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
HAWAII EARLY LEARNING PROFILE (HELP)	Assessment of developmental skills and behaviors	Ages 0 to 3 Boys & girls	Training required for use
PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)	Developmental Screening Tool – variety of domains	Birth to 8 years Boys & girls	Parent completion
TRAUMATIC SYMPTOM CHECKLIST FOR YOUNG CHILDREN (TSCYC)	Assessment of PTSD Symptoms	Normed separately for boys and girls Ages 3 to 5	Can be completed by paraprofes sionals
MCHAT (2009)	A parent report screening tool to assess risk for Autism Spectrum Disorder (ASD)	Designed for use at 18 – 24 months of age	Completed by parents and scored by pediatricians, child psychiatrists or child psychologists

E. PSYCHOTHERAPEUTIC INTERVENTIONS

There is strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnoses. Thus, these specialized approaches should be the initial interventions before considering a psychopharmacologic trial (see table on following page and the AdSS Policy 210).

The recommended psychotherapeutic treatment interventions outlined in the table below are supported by current studies and best practice. Determination of the best psychotherapeutic approach is done in conjunction with the CFT and qualified infant and early childhood behavioral health practitioners. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. Other examples of accepted therapeutic approaches with this population are referenced in AdSS Medical Policy 210. The psychotherapeutic intervention selected and length of treatment should be clearly documented in the clinical record.

Suggested Best Practice Interventions for Infants and Toddlers (Table not inclusive of all available therapeutic modalities – any modalities utilized will be at the discretion of the treating BHP or BHMP).

TYPE OF INTERVENTON	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
FAMILY THERAPY Training through various organizations, institutional or educational settings; Numerous master's level educational programs have dedicated programs in marriage and family therapy Marriage and Family Therapists receive specific training and clinical supervision that focuses on working with family members at the relationship level (e.g., parent- parent, parent- child or child-child)	Focus on conflict management and influence of marital conflict during high-risk perinatal period; can also be used prenatally; Goal is to ensure parent/guardian/ designated representative consensus regarding child's behavioral health status AND that parenting strategies are consistent	Infants, toddlers, preschoolers and family triad (e.g., including mother and father);	Intervention takes place at the marital relationship level, as well as the relationships between each parent and the child; focus on evaluating and changing interaction patterns between triadic members	Behavioral challenges are linked to patterns of relationship challenges; an intervention directed at one family member will always have an effect on another family member; Can change behavior by changing relationships (dyadic, triadic, family system) Theoretical assumptions, which guide family therapy intervention techniques, provide essential element of clinical framework for relationship- based work within Circle of Security, and Infant/Child Parent Psychotherapy

TYPE OF INTERVENTON	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
CHILD PARENT PSYCHOTHERAPY (CPP) Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principles	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and parent/ guardian/ designated representative	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with their high-risk parents/ guardian/ designated representative	Work at relationship level to promote partnership between child parent/guardian/ that results in increased positive interaction and reduced discordant relationship styles	Based on the premise that "nurturance, protection, culturally and age-appropriate socialization from the attachment figure(s) comprise the cornerstone of behavioral health in infancy and early childhood…"
INFANT PARENT PSYCHOTHERAPY Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principles	Similar to Child Parent Psychotherapy, but with greater emphasis on impact of upbringing of parent/guardian/ designated representative and how that impacts current parent/guardian/ designated representative perceptions of infant and relationship with infant	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express feelings	Focus on parent/child relationship to build relationship with parent by helping caregiver understand the basis for infant behaviors and perceptions of their world (e.g., behavior based on need for safety and security)	IPP more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological challenges of parent/guardian/ designated representative as child and how those challenges impact ability to act as nurturing, protective parent/guardian/ designated representative

CIRCLE OF SECURITY Training through Circle of Security International	Therapist builds trusting relationship with parent/guardian/ designated representative (secure base) as therapist moves through relationship- based interventions to identify relational distress	Infants, toddlers & preschoolers and their parent/guardian / designated representative	Use Circle of Security interview to gain information about parent/guardian /designated representative "internal working model" regarding relationship with their child	The need for a secure attachment base is essential for building healthy relationships *Based on Attachment Theory (joint work of John Bowlby and Mary Ainsworth; also based on relationship- based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*
APPLIED BEHAVIORAL ANALYSIS	Applied behavior analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior	Applied Behavioral Analysis Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnoses. An Early Intensive ABA (EI/ABA) program specifically for children with Autism Spectrum Disorder who begin treatment before age 4 has been described by Lovaas and others.	ABA techniques are used to decrease unwanted behaviors and increase desired behaviors through a systematic and consistent intervention. EI/ABA is provided with the goal of integrating a young child with ASD into a regular education classroom with reduced behavioral symptoms by the entry into Grade 1.	That systematic behavioral intervention can decrease unwanted behaviors and increase desired behaviors.

F. PSYCHIATRIC EVALUATION

General practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. Birth through five behavioral health significant efforts should be made to ensure that the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist with training or experience in the treatment of young children, aged 0 to 5.

The psychiatric evaluation for a young child continues to focus on gathering supplemental information that may be needed since completion of the comprehensive assessment. This is especially critical for identification of any additions or changes that may impact the child's functioning. Components may be very similar:

1. Information from those persons who are most familiar with the child, as well as direct observation of the child with their parent/guardian/designated representative especially if changes have occurred within the caregiver constellation since the initial assessment.

2. Any potential changes in the reason for referral including changes in the child's social, emotional, and behavioral symptoms.

3. Updates related to the detailed medical and developmental history.

4. Updates related to current medical and developmental concerns and status.

5. Changes in family, community, childcare, and cultural contexts which may influence a child's clinical presentation.

6. Newly identified parental and environmental stressors and supports.

7. Ongoing or recent changes in parent/guardian/designated representative perception of the child, ability to read/respond to child's cues, and willingness to interact with the child.

8. Use of the AdSS Medical Policy 210 to ensure use of evidence-based Behavioral Health Practice Tool for working with infants and toddlers.

9. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved.

10. Collaboration with other agencies involved with the child and family including, but not limited to, the Department of Child Safety, Division of Developmental Disabilities, Arizona Early Intervention Program (AzEIP), First Things First, Head Start, the local school district, Healthy Families Arizona and other educational programs.

11. Development of DSM-5 Diagnoses and DC: 0 to 5 Diagnosis following:

    - Diagnostic Classification of Behavioral health and Developmental Disorders in Infancy and Early Childhood" (DC: 0-5).

    - The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).

Current best practice for infants and toddlers, utilizes the DC: 0-5 for a number of reasons. First, it is based on behavioral health normed developmental trajectories, family systemic and relationship-based approaches, along with attention to individual differences in motor, cognitive, sensory, and language capabilities. Secondly, it allows for more thorough and developmentally appropriate diagnosis of behavioral health conditions in early

childhood. An important feature of the DC: 0-5 is that it includes both the DSM-5 diagnostic references, as well as the corresponding ICD-10 codes. The DC: 0-5 manual was first published in 1994 as the "DC 0-3" and then revised in 2016 by Zero to Three: National Center for Infants, Toddlers, and Families (now known as "Zero to Three").

G. PSYCHOPHARMACOLOGICAL INTERVENTIONS

1. General Guidelines

If it is determined that a psychopharmacologic intervention is indicated, goals of treatment should include facilitating normative developmental processes and maximizing the potential for effective psychotherapeutic interventions. Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions, as the evidence base for the treatment of young children under the age of five is quite limited.

Clear and specific target symptoms shall be identified and documented in the clinical record prior to the initiation of a medication trial. Target symptoms and progress are continually documented in the clinical record throughout the course of treatment (Division Medical Policy 940).

Medication is always started at the lowest possible dose with subsequent increases in medication undertaken with caution. Dosing can be challenging as young children may metabolize medications more rapidly than older children. In addition, children age birth through five experience rapid growth during this timeframe, which may change the dose that is required for optimal treatment over short periods. Since these young children are often very sensitive to side effects, they shall be monitored closely.

2. Informed Consent

Informed consent, as specified in AdSS Medical Policy 320-Q, is an active,

ongoing process that continues over the course of treatment through active dialogue between the prescribing BHMP and parent or responsible person about the following essential elements (Please refer to AdSS Medical Policy 310-V and AMPM Policy 310-V Attachment A for more information):

- The diagnosis and target symptoms for the medication recommended
- The possible benefits/intended outcome of treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- FDA status of the medication
- Level of evidence supporting the recommended medication.

Although there are medications approved by the Food and Drug Administration (FDA) for young children under the age of five, an FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. In addition, lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy. The Physician's Desk Reference states the following: "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. Thus, BHMPs shall document the rationale for medication choice and the provision of informed consent to parents/ guardians/designated representatives.

3. Monitoring

Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac and other functions or require serum level monitoring shall be assessed via appropriate laboratory studies and medical care shall be coordinated with the child's primary care physician.

4. Coordination of Care

In Arizona, the behavioral health program has historically been separated from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI). Both models have been structured in the past in such a way that eligible persons received general medical services through health plans and covered behavioral health services through a separate Contractor. Because of this separation in responsibilities, communication, and coordination between behavioral health providers, AHCCCS Health Plan primary care providers and behavioral health coordinators were essential to ensure the well-being of young children receiving services from both systems. Since October 1, 2019, there has been a system-wide shift toward medical health homes and provision of integrated and coordinated care, which is bringing about a shift in provider practices to address early intervention needs using a more holistic approach. Since October 1, 2019, the Division has contracted with the AdSS to implement integrated and coordinated behavioral health and physical health care.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care.

5. Polypharmacy

Polypharmacy is defined as using more than one psychotropic medication at a time with this population and is not recommended. This definition excludes a medication cross taper, where the young child may be on two medications for a short period in order to avoid abrupt withdrawal symptoms. More than one medication should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's

ability to form close relationships, experience, regulate and express their emotions, and developmental progress.

Complementary, alternative, and over-the-counter medications should be taken into consideration when evaluating the use of polypharmacy and potential drug interactions. If more than one medication is prescribed, there shall be documentation of clear target symptoms for each medication in the child's clinical record. When applicable, the Controlled Substance Prescription Monitoring Program (CSPMP) database should be checked (Refer to AdSS Medical Policy 940).

6. Medication Taper

In children who have a positive response to medication, as indicated by a remission of symptoms, a taper off medication should be considered at six to eight months of treatment. This consideration shall be clearly documented in the clinical record. The BHMP shall weigh the risks vs. benefits of each approach with the parent/guardian/designated representative, which includes the importance of reassessing the need for medication in the rapidly developing young child. Every six to eight months, a medication taper should be considered until the child reaches the age of five. The BHMP should reassess for a persistent diagnosis and need for continuing medication at reasonable intervals beyond age five.

If the decision to taper the child off medication is made, the CFT shall be informed of this decision in order to discuss and address possible behavior disruptions that may arise as a result of this taper. The CFT shall also ensure that the need for additional supports or services for the child and/or caregiver be considered and implemented as necessary to maintain the child's stability (For specific guidelines for children involved with the Department of Child Safety and/or foster care, refer to AMPM Behavioral Health Practice Tool 260, AdSS Medical Policy 320-Q, and A.R.S. § 8-514.05). Documentation of medication taper should be made with clinical rationale provided.

7. Prescription by a Non-Child Psychiatrist

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services to young children shall have training and possess experience in both psychotherapeutic and psychopharmacological interventions for children age birth through five. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible; in rural or underserved locations, this may be met through the use of telemedicine. A non-child psychiatrist BHMP shall adhere to the following when prescribing psychotropic medication for children birth through five years of age:

a. After the psychiatric evaluation has been completed and it is determined that the child may benefit from psychotropic medication(s), the case shall be reviewed with the designated child psychiatric provider as determined by the AdSS. The review shall include, at a minimum, the following elements:

i. The proposed medication with the starting dosage,
ii. Identified target symptoms,
iii. The clinical rationale for the proposed treatment,
iv. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/holistic providers,
v. Drug Review/Adverse Reactions,
vi. A plan for monitoring, potential side effects such as weight gain, and/or abnormal/involuntary movements, (based on recommended standards of care, and
vii. Identified targeted outcomes.

b. Follow-up consultation with a designated child psychiatric provider

shall occur in the following instances:

i. If the child is not making progress towards identified treatment goals (at minimum of every three months),

ii. In the event that reconsideration of diagnosis is appropriate,

iii. When a new medication is being considered or when more than one medication is prescribed.

H. BIRTH THROUGH FIVE EPSDT: ASSESSING PHYSICAL AND BEHAVIORAL NEEDS THROUGH DEVELOPMENTAL SURVEILLANCE, ANTICIPATORY GUIDANCE AND SOCIAL/EMOTIONAL GROWTH

AHCCCS has historically incorporated the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that members under the age of 21 receive appropriate preventive and early intervention services for physical and behavioral health conditions (refer to AdSS Medical Policy 430). Through formal policy and reporting requirements under CMS guidelines, participation has been measured in part through use of forms designated as “EPSDT Tracking Forms” (refer to AMPM Policy 430 Attachment E).

Although AHCCCS requires use of specific EPSDT forms available on the AHCCCS website, further guidance on the use of the forms is also available through Bright Futures. Both the Bright Futures website and Bright Futures Pocket Guide offer more detailed guidance on use of content within the tracking forms. The focus of the last section of this policy is to assist PCPs and/or pediatricians in identifying concerns related to three central EPSDT domains:

- Anticipatory Guidance,
- Developmental Surveillance, and
- Social/Emotional Growth.

Often, the primary care setting is the most robust situation available for parents to

address early developmental or behavioral concerns. During the course of EPSDT-required well-child visits, physicians and pediatricians have multiple opportunities over time to build relationships with parents and their young children, while simultaneously gathering valuable information. Through discussions guided by the use of the three domains listed above, they have the chance to identify strengths, needs and stressors for the parents and children that they follow. With thoughtful use of items within these domains, it is possible for physicians to identify a physical health concern that may also involve the need for further behavioral health services. For example, a language delay or developmental regression could be due to numerous physical causes. However, both are also symptoms of early childhood trauma for children birth to three years of age. Additionally, symptoms often associated with attention deficit hyperactivity disorder (ADHD) can mirror child traumatic stress.

The challenge for physicians, due to lack of training and knowledge, is often the ability to clearly identify behavioral and developmental concerns and then link parents/guardians/ designated representatives to adequate resources. Some physicians are comfortable providing basic treatment, whereas others are not. According to one study, PCPs had various comfort levels to conduct treatment or make referrals, but it related to the diagnoses involved. There was a comfort level treating ADHD but not depression – the preference for the latter, in most instances was to make a behavioral health referral.

Given acknowledgement to the lack of behavioral health training within the pediatric community, dedicated and thorough use of EPSDT forms, as well as guidance provided under Bright Futures, can aid physicians in providing appropriate and early intervention treatment for children birth through five. The center sections of EPSDT forms offer opportunity to work with parents/guardians/designated representatives to offer guidance and encourage referrals to and use of the behavioral health system when there is concern about behaviors that may indicate a potential behavioral health condition.

Although it is not the purpose of this policy to offer extensive details regarding early

childhood developmental and behavioral health issues, the table below provides some examples of how EPSDT Developmental Screening sections can prompt opportunities (based on specific age appropriate EPSDT domains) for discussion between parents/responsible person and PCPs regarding observations and concerns identified during visits. PCPs have multiple options at these visits to suggest community supports, case manager involvement (if available under the Medical Health Home model) or refer to behavioral health system/provider for further assistance (Refer to AdSS Medical Policy 580 for information on the Behavioral Health Referral Process).

The table below is designed to present bivariate ways (e.g., physical or behavioral) to examine developmental milestones, environmental factors and level of social/emotional growth. Because physical and familial environments have such a tremendous impact on the developing brain, it is important to recognize that if infants and toddlers are not meeting milestones, there could be either physical, environmental or behavioral health reasons.

EPSDT Domain Sample Table: Potential indicators for referral to BH services (Based on age, domain and need (AMPM Policy 430 Attachment E; Bright Futures, 4TH Edition)

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	6 months	Sits without support, babbles sound such as "ma", "ba", "ga", looks when name is called.	Parent/guardian/designated representative engages with and is attentive toward infant; if infant is engaging in these early milestone behaviors, and there is lack of reaction or acknowledgement from parent, or reciprocal engagement explore further for evidence of potential maternal depression or other environmental factors (unsafe environment, violence, neglect) that may be causing stress or trauma for the infant.
ANTICIPATORY GUIDANCE PROVIDED	6 months	Discussion of social determinants of health (e.g., safe sleep, sleep/wake cycles, tobacco use, safe environment).	Any potential risk factors identified under this domain may warrant referral for community supports or referral for behavioral health services if there is concern about parental depression, substance use, neglect of child or dangerous environment).

SOCIAL EMOTIONAL HEALTH	6 months	Appropriate bonding and responsive to needs.	Is parent/guardian/designated representative feeding infant and engaging while feeding or is infant being fed via bottle propping while in carrier or crib? Lack of infant/parent engagement may warrant further discussion and referral to behavioral health system due to potential indicators for maternal depression or lack of appropriate bonding/attachment. Lack of appropriate bonding can manifest in multiple ways (lack of eye contact between baby and caregiver, baby shows signs of discomfort when being held, inability for caregiver to help baby sooth).
ANTICIPATORY GUIDANCE PROVIDED	1 yr.	Continued focus on social determinants of health such as food security, safe environment, parental use of tobacco, alcohol or other substances.	If there are parental risk factors for social determinants of health, there are opportunities to refer for community supports or behavioral health; in case there are underlying behavioral health needs (e.g., parental depression, substance use).
SOCIAL EMOTIONAL HEALTH	1 yr.	Prefers primary caregiver over others, shy with others, tantrums.	Lack of preference for primary caregiver could indicate insecure attachment for variety of reasons (e.g., lack of trust, abuse, neglect, early trauma); consider unaddressed behavioral health issues in parent.
DEVELOPMENTAL SURVEILLANCE	3 yrs.	Eats independently, uses three word sentences, plays cooperatively and shares.	Lack of these observed developmental milestones may be indicative of physical issues or lack of parental engagement with child; consider referral for community supports and/or behavioral health system to address potential for undiagnosed behavioral health issue on the part of the parent or child (barring any evidence of physical reasons).

DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
ANTICIPATORY GUIDANCE PROVIDED	3 yrs.	Allow child to play independently; be available if child seeks out parent or caregiver.	Attachment issues can manifest as fear in child to play independently, even if allowed (over- dependence on caregiver), or reluctance of child to seek out parent/guardian/designated representative due to lack of secure "attachment" base. Could also be signs/symptoms related to abuse.
SOCIAL EMOTIONAL HEALTH	3 yrs.	Separates easily from parent, shows interest in other children, kindness to animals.	Observe parental conversations and interaction; is parent positive with child, offering praise, setting appropriate boundaries; lack of these observed behaviors on the part of either parent or child may indicate unaddressed child/parent relationship issues or potential mental issue issues for either parent or child.

I. DIVISION OVERSIGHT OF AdSS

The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of standards related to birth to age five.

2. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and providing direction or support to the AdSS as necessary.

3. Ensure AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: _____
Anthony Dekker (Apr 28, 2022 10:36 PDT)
Anthony Dekker, D.O.

230 SUPPORT AND REHABILITATION SERVICES FOR CHILDREN, ADOLESCENTS AND YOUNG ADULTS

EFFECTIVE DATE: June 22, 2022

REFERENCES: A.A.C. R9-10-115, AMPM Chapter 200, AdSS 320-O

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS).This policy establishes the expectations for the implementation of support and rehabilitation services as they are used in Child and Family Team (CFT) practice.

DEFINITIONS

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM). A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health

services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Support and Rehabilitation Service Providers provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration, or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

BACKGROUND

In March of 2007, ADHS/DBHS launched the Meet Me Where I Am (MMWIA) campaign with the intention of increasing the availability of Support and Rehabilitation Services. As a result of Administrative Simplification this goal remains a priority of AHCCCS. As part of the MMWIA campaign, 9 modules were created and placed online offering assistance to practitioners of Direct Support Services. These modules can be accessed at mmwia.com and referenced in this document.

POLICY

Support and Rehabilitation Services are an essential part of community-based practice and culturally competent care. These services help children live successfully with their families in the community. Adhering to the expectations of this policy will enhance behavioral health outcomes for children and young adults by improving the integration of Support and Rehabilitation Services with CFT Practice; clarifying the expectations

regarding Support and Rehabilitation Service development; and outlining responsibilities with respect to Support and Rehabilitation Services processes.

A. SERVICE DEVELOPMENT

The AdSS shall develop sufficient Support and Rehabilitation Service capacity to meet the behavioral health needs of youth and families, as identified in their CFTs. The AdSS shall ensure the following occurs in relation to service development:

1. CFTs have timely access to the full range of Support and Rehabilitation Services, in alignment with AdSS Operations Policy 417.

2. CFT facilitators and families are aware of the value of Support and Rehabilitation Services, as well as specific and current information regarding the different provider options available in their area.

3. The AdSS shall adopt a Support and Rehabilitation Services system model outlining how these services will be structured in their region, and their relation to other behavioral health services and providers (Refer to Module 9, System and Program Models for Support and Rehabilitation Services Provision, of the online MMWIA modules for more information).

4. Support and Rehabilitation Services are available to meet the behavioral health needs of youth and families as identified in their CFTs.

B. INTEGRATING SUPPORT AND REHABILITATION SERVICES WITH CFT PRACTICE

The CFT shall complete the following tasks when planning and arranging for Support and Rehabilitation Services (Refer to Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, of the online MMWIA modules for detailed information about each task):

1. Assess the underlying needs of the child/family and consider the various options presented through Support and Rehabilitation Services for meeting those needs. These options may include family, natural and community resources, resources of other involved stakeholder agencies (such as DCS, DDD, and family-run support or advocacy organizations) as well as paid behavioral health resources. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan. Refer to AdSS Medical Policy 320-O. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan.

2. Locate and select Support and Rehabilitation Services provider(s) to help implement the plan. Collaborate with and use information provided by the Contractors to do the following:

    a. Determine which Support and Rehabilitation Services providers may meet the needs identified, determine whether those providers have current capacity, and

b. Make a referral to the selected provider(s).

3. Work with the Support and Rehabilitation Services provider(s) to define their roles and tasks, specifying the anticipated frequency and duration associated with the Support and Rehabilitation Services requested. The CFT ensures this information is recorded in the service plan and the Support and Rehabilitation Services provider(s) promptly receive a copy of the plan. If unplanned services are needed due to crisis situations, the CFT notes this change in the service plan and the Support and Rehabilitation Services provider is authorized to respond with additional support if needed.

4. Coordinate effectively with the Support and Rehabilitation Services providers on an ongoing basis. This may be accomplished through CFT meetings as well as through regular communication with the Support and Rehabilitation Services provider. The CFT Facilitator/behavioral health case manager sends the Support and Rehabilitation Services provider a complete Referral Packet which includes copies of any updated assessments, service plans, notice of change to funding status, and other important documents whenever updates occur.

5. Support and Rehabilitation Services shall be documented accurately and differentiate between which services were provided. Module 1, Overview of Support and Rehabilitation Service Provision, of the MMWIA modules provides several appendices intended to assist with code differentiation and billing limitations of Support and Rehabilitation Services.

6. Monitor progress and adjust the Support and Rehabilitation Services provision as necessary. The CFT, which includes the Support and Rehabilitation Services provider, makes necessary adjustments to the authorized Support and Rehabilitation Services. These include the type, anticipated frequency and duration of the service(s), as well as and documents any changes in the service plan. CFTs meet regularly and make needed adjustments in the implementation of Support and Rehabilitation Services, both when services are successful and when they need to be modified because they are not achieving desired results.

7. All support and Rehabilitation Services should be provided using a Positive Behavior Support (PBS) philosophy. Module 3, Using Positive Behavior Support to Provide Effective Support and Rehabilitation Services, of the online MMWIA modules contains information regarding this type of approach. PBS is intended as a meta-theory to guide Support and Rehabilitation Services provision rather than as a specific type of program. It is not the intent of the Division to prescribe specific programming practices, but rather to endorse the principles underlying Positive Behavior Support, such as focus on strengths, enhancing quality of life and eliminating coercive or punitive approaches.

8. When clinically appropriate, the CFT will direct a plan to discontinue formal Support and Rehabilitation Services delivery ensuring that the youth and family have been connected to

community resources or services and natural support services that will provide ongoing support. (Refer to MMWIA Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, for more information about when it may be appropriate to end Support and Rehabilitation Services as well as suggestions for transition from these services).

C. RESPONSIBILITIES REGARDING SUPPORT AND REHABILITATION SERVICES PROCESSES

1. AdSS and their network of behavioral health providers shall maintain and make available to the CFT, current and accurate information regarding Support and Rehabilitation Services providers and their current capacity/availability to provide support.

2. AdSS and their network of behavioral health providers shall require that Support and Rehabilitation Services providers use a standardized referral process that helps providers receive, store, track, and respond in writing to all referrals received from CFT facilitators/case managers.

3. To better assess the need for increased Support and Rehabilitation Services capacity, AdSS and their network of behavioral health providers shall monitor information from CFT Facilitators/case managers who are unable to locate Support and Rehabilitation Services requested by the CFT in a timely manner. Information gathered may include the date of the request(s), number of providers approached, the type and/or amount of

Support and Rehabilitation Services sought by the team, and what the team did as an alternative to address the needs of the youth and family.

4. AdSS and their network of behavioral health providers shall create and oversee a process whereby Support and Rehabilitation Services providers receive copies of any and all of the following documents in a timely manner each time they are updated. These documents are needed for quality service provision, and may also be necessary in the event of data validation audits they include:

   a. Assessments and Addenda,

   b. Review of Progress forms,

   c. Service Plan Documents,

   d. Data demographic forms,

   e. Crisis/Safety Plans,

   f. Strengths, Needs and Culture Discoveries, and

   g. Child and Family Team Notes (if separate from the above items).

5. AdSS and their network of behavioral health providers shall ensure that procedures are in place to require Support and Rehabilitation Services providers to do the following:

   a. Respond to referrals in a timely manner (Refer to AdSS

Operations Policy 417),

b. Participate actively in Child and Family Teams,

c. Provide information regarding service delivery as it relates to established child/family goals, and

d. Provide training and supervision necessary to help staff members provide effective Support and Rehabilitation Service as outlined by the CFT.

6. AdSS and their network of behavioral health providers shall develop a process to ensure that when children and families are receiving intense Support and Rehabilitation Services or are receiving them for an extended period of time, services are reviewed periodically to ensure resources are being used effectively. Such review should be done in person with the CFT rather than outside of the team. During such reviews, case-specific factors identified by the CFT as being important to the success of the family must be considered.

7. AdSS and their network of behavioral health providers shall develop processes to track outcomes of Support and Rehabilitation Services both qualitatively (such as narrative success stories) and quantitatively (such as outcome data).

D. TRAINING AND SUPERVISION RECOMMENDATIONS

1. AdSS and their network of behavioral health providers shall establish processes for ensuring all clinical and support services staff working with children and adolescents understand the elements for development and use of Support and Rehabilitation

Services as specified in this document through formal training as noted here, including required reading of this Policy.

2. A number of training resources have been developed as part of the MMWIA campaign to assist families, providers, and community members in using Support and Rehabilitation Services effectively. Specifically, nine self-guided training modules/toolkits are available for any individuals or agencies across the state that participates in CFTs. These modules may be accessed online at www.mmwia.com.

3. AdSS and their network of behavioral health providers shall provide documentation, upon request from the Division or AHCCCS, demonstrating that all required network and provider staff have been trained on the elements contained in this policy. Whenever this policy or the attendant training modules are updated or revised, AdSS shall ensure their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

4. Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in accordance with A.A.C. R9-10-115 Behavioral Health Paraprofessionals; Behavioral Health Technicians.

E. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division oversight activities including,

but not limited to the following methods to ensure compliance with this policy and associated policies:

1. Annual Operational Review of compliance with this policy and related standards, including but not limited to:
   a. Policies/procedures for, and evidence of, assessing and prioritizing identified need for MMWIA services.
   b. Policies/procedures for, and evidence of, tracking and documenting demand/unmet need for MMWI services.
   c. Policies/procedures, and evidence of, implementing strategy for addressing the lack of timely availability of MMWIA services.
   d. Policies/procedure, and evidence of, managing and documenting service utilization/length of stay for MMWIA services.
   e. Evidence of training as described in section Training and Supervision above.
2. Submit deliverable reports or other data as requested by the Division.
3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.
4. Conduct ongoing monitoring and demonstrate evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:30 PDT)
Anthony Dekker, D.O.

280 TRANSITION TO ADULTHOOD

EFFECTIVE DATE: June 29, 2022

REFERENCES: A.A.C. R4-6-212, IDEA Part B, Section 1415 (m), Section 504 of the Rehabilitation Act of 1973

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to strengthen practice in the system of care and promote continuity of care through collaborative planning by:

1. Supporting individuals transitioning into early adulthood in ways that reinforce their recovery process.
2. Ensuring a smooth and seamless transition from the AHCCCS Children System of Care to the AHCCCS Adult System of Care.
3. Fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of 18.

DEFINITIONS

Adult Recovery Team (ART) is a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member, member's health care decision maker (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals

representing various areas of expertise related to the member's needs, or other individuals identified by the member.

Assessment – Behavioral Health means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) is a group of individuals that includes, at a minimum, the child and their family, or health care decision maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality

of life.

Serious Mental Illness is a designation as specified in A.R.S. 36-550 and determined in an individual 18 years of age or older.

Serious Mental Illness Evaluation is the process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a determination as to an individual's serious mental illness eligibility.

BACKGROUND

The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated: "Traditionally, early adulthood has been a period when young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development." While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.

Between 2008 and 2017, the number of adults that experienced serious psychological distress in the last month increased among most age groups, with the largest increases seen among younger adults aged 18-25 (71%). Notably, rates of serious psychological distress increased by 78% among

adults aged 20-21 during the time period. Meanwhile, there was a decline among adults aged 65 and older.

These findings were consistent across other measures, with the rate of adolescents and young adults experiencing depressive symptoms in the last year increasing by 52% and 63%, respectively, while rates remained stable adults aged 26 and older.

As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially getting married and becoming parents. While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more “intangible, gradual, psychological, and individualistic terms.” Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting “responsibility for the consequences of your actions,” deciding one’s “own beliefs and values independently of parents or other influences,” and establishing “a relationship with parents as an equal adult.”

Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.

With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20’s may still require the support of their

families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities. For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.

Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a serious mental illness. Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.

POLICY

This policy addresses the recommended practice for transitioning youth from the AHCCCS Children System of Care to the AHCCCS Adult System of Care with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood. The AdSS shall follow the procedures specified in AdSS Medical Policy 520, which requires that transition planning begins when the youth reaches the age of 16, however, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning

earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age 16 and older at the time they enter the AHCCCS System of Care, planning must begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the AHCCCS Adult System of Care, but also as a transition to adulthood.

A. SERIOUS MENTAL ILLNESS DETERMINATIONS

1. When the adolescent reaches the age of 17 and the CFT believes that the youth may meet eligibility criteria as an adult designated as having a Serious Mental Illness (SMI), the Contractor and their subcontracted providers must ensure the young adult receives an eligibility determination at the age of 17.5, as specified in AdSS Medical Policy 320-P.
2. If the youth is determined eligible, or likely to be determined eligible for services as a person with a SMI, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services case manager to upcoming planning meetings. When more than one behavioral health service provider is involved, the responsibility for collaboration lies with the provider who is directly responsible for behavioral health service planning and delivery.
3. If the young adult is not eligible for services as a person with a

SMI, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

B. REQUIREMENTS FOR INFORMATION SHARING PRACTICES, ELIGIBLE SERVICE FUNDING, AND DATA SUBMISSION UPDATES

1. Prior to releasing treatment information, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per AdSS Medical Policy 940.
2. The behavioral health provider will ensure that the behavioral health category assignment is updated along with other demographic data consistent with the AHCCCS Technical Interface Guidelines.
3. Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning. A full assessment is not

required at the time of transition from child to adult behavioral health services unless an annual update is due or there have been significant changes to the young adult's status that clinically indicate the need to update the Assessment or Individual Recovery Plan.

C. KEY PERSONS FOR COLLABORATION

1. Team Coordination:

When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. This coordination must be in place no later than four - six months prior to the youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.

Orientation of the youth, their family and CFT to potential changes they may experience as part of this transition to the AHCCCS Adult System of Care will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an

ambassador for the incoming young adult and their involved family and/or caregiver.

As noted in the AMPM, Policy 220, the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain their current CFT until the youth turns 21. Regardless of when the youth completes their transition into the AHCCCS Adult System of Care, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Collaboration between the child and adult service provider for transition age youth is more easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.

2. Family involvement and culture must be considered at all times, especially as the youth prepares for adulthood. Although this period in a young person's life is considered a time for establishing their independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.

During this transitional period the role that families assume upon their child turning 18 will vary based on:

a. Individual cultural influences,

b. The young adult's ability to assume the responsibilities of adulthood,

c. The young adult's preferences for continued family involvement, and

d. The needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.

3. Understanding each family's culture can assist teams in promoting successful transition by:

a. Informing families of appropriate family support programs available in the AHCCCS Adult System of Care,

b. Identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the AHCCCS Adult System of Care,

c. Recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence, and

d. Addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.

Some youth involved with DCS may express a desire to reunite with their family from whose care they were removed. In these situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.

D. SYSTEM PARTNERS

Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18. Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 22. Youth in foster care may be eligible for services through a program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP) through the Arizona Department of Child Safety (DCS).

System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:

1. Birth certificates.
2. Social security cards and social security disability benefit applications.
3. Medical records including any eligibility determinations and assessments.
4. Individualized Education Program (IEP) Plans.
5. Certificates of achievement, diplomas, General Education Development transcripts, and application forms for college.
6. Case plans for youth continuing in the foster care system,
7. Treatment plans.

8. Documentation of completion of probation or parole conditions.
9. Guardianship applications.
10. Advance directives.

E. NATURAL SUPPORT

Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:

1. Identify what supports will be needed by the young adult to promote social interaction and relationships.
2. Explore venues for socializing opportunities in the community.
3. Determine what is needed to plan time for recreational activities.
4. Identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.

F. PERSONAL CHOICE

Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist

them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf. This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:

1. Arizona Vision and 12 Principles for Children's Service Delivery, and
2. Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.

G. CLINICAL AND SERVICE PLANNING CONSIDERATIONS

The AdSS shall support clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the AHCCCS Adult System of Care. This partnership is built through respect and equality, and is based on the expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.

H. CRISIS AND SAFETY PLANNING

The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as specified in the AMPM, Policy 220. For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the AHCCCS Adult System of Care and how to access them in their time of need.

I. TRANSITION PLANNING

The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.

1. Self-care and Independent Living Skills

   As the youth approaches adulthood, the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills,

how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.

2. Social and Relational Skills

The young adult's successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or

transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.

3. Vocational/Employment

An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.

Service planning that addresses the youth's preparation for employment or other meaningful activity can include:

a. Utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities,

b. Identifying skill deficits and effective strategies to address

these deficits,

c. Determining training needs and providing opportunities for learning through practice in real world settings,

d. Learning about school-to-work programs that may be available in the community and eligibility requirements,

e. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, and

f. Learning federal and state requirements for filing annual income tax returns.

Youth involved in school-based work activities (paid or non-paid) are able to “test the waters” of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth’s freshman year of high school. When youth reach the age of 14 they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work-related opportunities will assist teams in determining where the youth excels or struggles in each type of work undertaken, the types of

supports that might be needed, and what the best "job match" might be in terms of the youth's personal interests and skill level.

As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth's chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment. Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as well as employer related accommodations may be necessary to ensure that the young adult can continue to perform their job duties.

4. Vocational/Employment Considerations for Youth with Disabilities

For youth who have a disability, regardless of whether they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) under a Vocational Rehabilitation (VR) program when transitioning from school to work. The school can refer youth with a disability to the VR program as early as age 14 or at any time thereafter when they are ready to work with VR to address their career plans. Students with disabilities between the ages of 14 and 22 are able to participate in Pre-Employment Transition Services as potentially eligible students, meaning they do not have to be VR clients. Pre-Employment Transition Services are group based, general workshops covering five topic areas that may provide the information a youth needs to begin the career exploration process, develop skills for successful employment, and

learn about post-secondary education opportunities. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment. Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for DES/RSA program services. Refer to DES/RSA for information on the VR process regarding intake/eligibility, planning for employment, services, and program limitations.

5. Education

   Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. Asking the youth to share their individualized plans with the rest of the team may provide information to assist with transition planning. Individualized plans could include:

   a. Education Career Action Plan (ECAP),

   b. 504 Plan,

   c. Transition Plan, and

   d. Summary of Performance.

6. Individualized Plans

   a. Educations Consideration for all Students:

      i. Education Career Action Plan - In 2008 the Arizona State Board of Education approved Education and Career Action Plans for all Arizona students in grades

9-12. The ECAP is intended to develop the young adult's individual academic and career goals. An ECAP process portfolio has for attributes that should be documented, reviewed and updated, at minimum, annually; academic, career, postsecondary, and extracurricular.

b. Education Considerations for Youth with Disabilities:

i. 504 Plan — Section 504 of the Rehabilitation Act of 1973 protects the civil rights of individuals with disabilities in programs and activities that receive federal funds. Recipients of these funds include public school districts, institutions of higher education, and other state and local education agencies. This regulation requires a school district to provide accommodations that can be made by the classroom teacher(s) and other school staff to help students better access the general education curriculum through a 504 Plan that outlines the individualized services and accommodations needed by the student,

ii. Transition Plan - While youth are in secondary education, Individuals with Disabilities Educational Act (IDEA) requires public schools to develop an individualized transition plan for each student with an IEP. The transition plan is the section of the IEP that is put in place no later than the student's 16th birthday. The purpose of the plan is to develop postsecondary

goals and provide opportunities that will reasonably enable the student to meet those goals for transitioning to adult life. All of the following components are required as part of the transition plan:

1) Student invitation to all IEP meetings where transition topics are discussed.
2) Age-appropriate transition assessments.
3) Measurable Postsecondary Goals (MPGs) in the areas of:
    a) Education/Training,
    b) Employment, and
    c) Independent living, (if needed).
4) Annually updated MPGs.
5) Instruction and services that align with the student's MPGs:
    a) Coordinated set of transition activities,
    b) Courses of study, and
    c) Annual goals.
6) Outside agency participation with prior consent from the family or student that has reached the age of majority.
    a) Summary of Performance (SOP). The SOP is required under the reauthorization of the

IDEA Act of 2004. An SOP is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE under State law. In Arizona, the student reaches the maximum age of eligibility upon completing the school year in which the student turns 22. A Public Education Agency must provide the youth with a summary of their academic achievement, functional performance, and recommendations on how to assist in meeting the young adult's postsecondary goals. The SOP must be completed during the final year of a student's high school education.

7. Other Considerations

a. Transfer of Rights' Requirement for Public Education Agencies. Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

i. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to

the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18, and

ii. In order to prepare youth with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health provider, should assist the youth/parent/caregiver with this process.

b. A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.

8. Postsecondary Education Considerations

When postsecondary education is the goal for young adults, transition planning may include preparatory work in a number of areas, including, but not limited to, matching the young adult's interests with the right school, connecting the youth to the preferred schools Disability Resource Center if accommodations are needed, assisting with applications for scholarships or other

financial aids, etc. The CFT should anticipate and help plan for such needs. If accommodations are needed, connect the youth with the Disability Resource Centers from their preferred postsecondary institutions, and

9. Medical/Physical Healthcare

   Planning can include assisting the youth with:

   a. Transferring healthcare services from a pediatrician to an adult health care provider, if pertinent,

   b. Applying for medical and behavioral health care coverage, including how to select a health plan and a physician,

   c. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services,

   d. Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures),

   e. Information on advance directives, as indicated in the Division Medical Policy 640,

   f. Methods for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication,

   g. How to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis, and

   h. Assuming responsibility for understanding and managing the symptoms of their mental illness and obtaining knowledge of

the benefits, risks, and side effects of their medication.

10. Living Arrangements

Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home with family, with a relative, in a behavioral health inpatient or residential facility, other out-of- home treatment setting), or whether they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently, identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting their needs and addresses any personal safety concerns.

The most common types of living situations range from living independently in one's own apartment with or without roommates to a supported or supervised type of living arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to Arizona 2-1-1 for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs**.**

Youth living in a behavioral health inpatient facility at the time they turn age 18 can continue to receive residential services until

the age of 22 if they were admitted to the facility before their 21st birthday and continue to require treatment.

Licensed residential agencies may continue to provide behavioral health services to individuals aged 18 or older if the following conditions are met as specified in A.A.C. R9-10-318 (B):

a. Person was admitted before their 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job training program, is not 21 years of age or older, or

b. Through the last day of the month of the person's 18th birthday.

11. Financial

Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security Disability programs, food stamps, or other emergency assistance will cover the young adult's financial responsibilities. Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.

Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for Social Security Income (SSI) benefits as a child will have a disability

redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits. The team can assist the young adult and their family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.

Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:

a. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions,

b. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area,

c. Learning how to monitor spending and budget financial resources,

d. Education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments, and

e. Understanding the short and long-term consequences of poor financial planning (e.g., overdrawn account [Non-Sufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss).

12. Legal Considerations

Transition planning that addresses legal considerations ideally begins when the youth is 17.5 years of age to ensure the young adult has the necessary legal protections upon reaching the age of majority. This can include the following:

a. Document Preparation

Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:

i. Guardianship,

ii. Conservator,

iii. Special needs trust, and

iv. Advance directives (e.g., living will, powers of attorney).

b. Legal Considerations for Youth with Disabilities

Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally

recognized fashion to help manage facets of their life. Refer to the Arizona Center for Disability Law's Legal Options Manual for access to information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

13. Transportation

A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.

When transitioning to the adult behavioral health system, educate the family and young adult on the transportation options available through the adult service delivery system. This will help support

the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with identifying and planning for other transportation needs that are not necessarily associated with accessing medical or behavioral health services.

14. Personal Identification

The team can assist the youth with acquiring a State issued identification card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division. An identification card is available to all ages (including infants); however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.

15. Mandatory and Voluntary Registrations

Selective Service registration is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security Number is not needed. When a Social Security Number is obtained after registration is completed, it is the responsibility of the young adult male to inform the selective Service System.

Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.

J. TRAINING AND SUPERVISION RECOMMENDATIONS

1. The practice elements of this policy apply to the AdSS and subcontracted network and provider behavioral health staff who participate in assessment and service planning processes, provider case management and other clinical services, or who supervise staff that provide service delivery to adolescents, young adults, and their families.
2. The AdSS shall establish a process for ensuring the following:
    a. Staff are trained and understand how to implement the practice elements outlined in this policy;
    b. The AdSS' network and provider agencies are notified of changes in policy and additional training is available if required; and
    c. Upon request from AHCCCS or the Division, the AdSS shall provide documentation demonstrating that all required network and provider staff have been trained on this policy.
3. The AdSS shall monitor their network and provider agencies for incorporation of this policy into other supervision processes the network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212, Clinical Supervision requirements.

K. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division's oversight requirements to ensure compliance with this policy and associated policies, including but not limited to the following:

1. The Division's Annual Operational Review of compliance with standards for Transition Aged Youth (TAY) and related evidence-based programs, including but not limited to:
    a. Policies/procedures to promote, and evidence of, adequate programming for TAY utilizing the Transition to Independence (TIP) Model, or other evidence-based programs for this population.
    b. Policies/procedures to track numbers, and evidence of, staff currently trained in TIP evidence-based programs.
    c. Policies/procedures to analyze, and evidence of, sufficiency of current First Episode Psychosis (FEP) programming for TAY (aged 18-24).
    d. Evidence of the completing an analysis of the data in Sections J.(1)(a.)(b.)(c.) and any related plans for developing additional FEP programming for TAY.
2. Submit deliverable reports or other data, as required, including but not limited to Provider Network Development and Management Plans demonstrating network adequacy and plans to promote specialty services described in this policy.
3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.
4. Submit data demonstrating ongoing compliance monitoring of network and provider agencies through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 24, 2022 10:14 PDT)
Anthony Dekker, D.O.

310-B TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES

REVISION DATE: 8/2/2023, 3/17/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: CFR 493, Subpart A; CFR Title 42, Chapter IV, Subchapter G, Part 482; 42 CFR 440.10; 42 CFR 441; 42 CFR 483; A.R.S. Title 32, Chapter 33; A.R.S. Title 36, Chapter 4; A.R.S. §32-3251; A.R.S. §36-501; A.R.S. §32-2061; A.R.S. §32-2091; A.A.C. R9-22-210.01; A.A.C. 14-101; A.A.C. R4-6-101; A.A.C. R9-10-200; A.A.C. Title 9, Chapter 10 (9 A.A.C. 10); A.A.C. R9-10-1016; A.A.C. R9-10-1012; A.A.C. R9-21-20; A.A.C. R9-10-316; A.A.C. R9-10-318; A.A.C. R9-10-316; A.A.C. R9-10-1025; A.A.C. R9-10- 1600; A.A.C. R9-10-1000; A.A.C. R9-10-300; AMPM Chapter 100; AMPM 109; AMPM Exhibit 310-1; AMPM 310-B; AMPM 310-BB; AMPM 310-V; AMPM 320-0; AMPM 320-S; AMPM 320-V; AMPM 320-W; AMPM 320-X; AMPM 570; AMPM 590; AMPM 963; AMPM 964; AMPM 965; ACOM Policy 447; ACOM Policy 436

PURPOSE

This policy describes Title XIX/XXI behavioral health services available to Division of Developmental Disabilities (Division) members who are enrolled with an Administrative Services Subcontractors (AdSS) and establishes requirements for behavioral health services.

DEFINITIONS

1. “Bed Hold” means days in which the facility reserves the member’s bed, or member’s space in which they have been

residing, while the member is on an authorized/planned overnight leave from the facility for the purposes of therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning as specified in Pursuant to the Arizona State Plan under Title XIX of the Social Security Act.

2. "Behavioral Health Paraprofessional" or "BHPP" means an individual who is not a Behavioral Health Professional who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:
   a. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and
   b. Are provided under supervision by a Behavioral Health Professional.
3. "Behavioral Health Professional" or "BHP" means

a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
b. A psychiatrist as defined in A.R.S. §36-501,
c. A psychologist as defined in A.R.S. §32-2061,
d. A physician,
e. A behavior analyst as defined in A.R.S. §32-2091,
f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
g. A registered nurse with:
    i. A psychiatric-mental health nursing certification, or
    ii. One year of experience providing Behavioral Health Services

4. "Behavioral Health Services" means a Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.
5. "Behavioral Health Technician" or "BHT" means an individual who is not a BHP who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:
    a. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
    b. Health Related Services
6. "Clinical Oversight" means monitoring the Behavioral Health Services provided by a Behavioral Health Technician to ensure that the Behavioral Health Technician is providing the Behavioral Health Services according to the Health Care Institution's policies and procedures by:

a. Providing on-going review of a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services,

b. Providing guidance to improve a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services, and

c. Recommending training for a Behavioral Health Technician to improve the Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services.

7. "Clinical Team" means Child and Family Teams and Adult Recovery Teams.

8. "Community Service Agencies" or "CSA" means an unlicensed provider of non-medical, health related, support services. CSAs provide:

a. Individualized habilitation,

b. Developmental learning,

c. Rehabilitation,

d. Relearning or readapting,

e. Employment,

f. Advocacy services,

g. Peer support, and

h. Family support.

9. "Family Support Services" means home care training with Family Members directed toward restoration, enhancement, or maintenance of the family functions in order to increase the family's ability to effectively interact and care for the individual in the home and community.

10. "Health Care Institution" means every place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, behavioral health services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies, outdoor behavioral health care programs and hospice service agencies.

11. "Medication Management" means medication management services such as:
    a. Review of medication(s) side effects, and
    b. The adjustment of the type and dosage of prescribed medications.
12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "Peer and Recovery Support" means intentional partnerships based on shared, lived experiences of living with behavioral health and/or substance use disorders to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

14. "Peer Services" means support intended for enrolled members or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
15. "Planning Team" means a defined group of individuals that shall include the Member or Responsible Adult and with the Member or Responsible Adult's consent, their individual representative, Designated Representative (DR), and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious or spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

16. "Room and Board" means the amount paid for food or shelter. Medicaid funds can be expended for Room and Board when an individual lives in an institutional setting. Medicaid funds cannot be expended forRoom and Board when a member resides in an Alternative Home and Community Based Service (HCBS) Setting.
17. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, Peer-and-Recovery Support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
18. "Vocational Rehabilitation" means a program under Rehabilitation Services Administration (RSA) that provides a variety of services to persons with disabilities, with the goal to prepare for, enter into, or retain employment.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall provide medically necessary Behavioral Health Services to Division Members that are consistent with Arizona

Health Care Cost Containment System (AHCCCS) coverage guidelines under Title XIX/XXI Behavioral Health Services.

2. The AdSS shall ensure that providers utilize national coding standards including the use of applicable modifier(s) as listed in the AHCCCS medical coding resources webpage and AHCCCS Behavioral Health Services matrix.
3. The ADSS shall cover medically necessary outpatient Behavioral Health Services regardless of a Member's diagnosis, so long as there are documented behaviors or symptoms that will benefit from Behavioral Health Services.
4. The AdSS shall ensure that Service Plan services are provided timely and in accordance with requirements included in AHCCCS Medical, Policy Manual (AMPM) Policy 320-0.
5. The AdSS shall ensure that services are not delayed or pended in order to have all team members present for a Service Planning meeting, or until all team members are able to sign off on the Service Plan.

6. The AdSS shall ensure providers make available and offer the option of having a Peer Recovery Support Specialist (PRSS) or Family Support Specialist for child or adult Members and their families to provide covered services when appropriate.
7. The AdSS shall establish policies and procedures to ensure Members on any form of Medication Assisted Treatment (MAT) are not excluded from services, or admission to any treatment program or facility based upon the use of MAT.
8. The AdSS shall ensure that emergency Behavioral Health Services are being provided, including crisis intervention services, without prior authorization being required.
9. The AdSS shall ensure that Behavioral Health Professionals (BHP) provide supervision to Behavioral Health Paraprofessionals (BHPPs) and Behavioral Health Technicians (BHTs) that provide services in the public behavioral health system.
10. The AdSS shall ensure that BHPs providing Clinical Oversight of BHTs have demonstrated competence in delivering the same or similar services to Members of comparable acuity and intensity

of service needs as the BHTs they supervise, in addition to possessing the requisite licenses and other qualifications.

11. The AdSS shall ensure that the BHPs providing Clinical Oversight of BHTs demonstrate the following key competencies:
    a. Demonstrated knowledge of the relevant best clinical practices and policies that guide the services being provided;
    b. Demonstrated knowledge of the policies and principles governing ethical practice;
    c. Demonstrated ability to develop individualized BHT competency development goals and action steps to accomplish these goals; and
    d. Demonstrated ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.
12. The AdSS shall ensure that Behavioral Health Services are provided to the Member's family members who consent to receiving these services, regardless of the Family Member's Title

XIX/XXI entitlement status, as long as the Member's Service Plan reflects that the provision of these services is aimed at accomplishing the Member's Service Plan goals.

13. The AdSS shall not require that the Member be present when the services are being provided to Family Members.
14. The AdSS shall allow as a covered service provided through indirect contact with members includes:
    a. Email or phone communication, excluding leaving voicemails, specific to a Member's services;
    b. Obtaining collateral information; and
    c. Picking up and delivering medications. Refer to the AHCCCS behavioral health service matrix and AHCCCS medical coding resource webpage for requirements for billing and indirect contacts.
15. The AdSS shall not cover Room and Board except for inpatient hospitals, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID), and nursing facilities (NF).

16. The AdSS shall ensure that the referral process to initiate Behavioral Health Services meets the following requirements:
    a. Providers shall not require a referral to initiate Behavioral Health Services.
    b. Members may directly request assistance from their Support Coordinator or their health plan's Member services department to initiate services or to identify a contracted service provider.
    c. If a provider's service array does not include a service required by a Member, the provider shall make a referral to a provider with the Member's assigned health plan, who does offer the necessary service.
    d. Providers shall make a referral to a provider who does offer the necessary service with the member's assigned health plan if Behavioral Health Services are not available within their service array.
17. The AdSS shall ensure transportation services are provided per AMPM 310-BB.

18. The AdSS shall ensure that behavioral health providers are eligible to bill for travel to and from a service location per AMPM 310-B to provide a covered behavioral health service. The AdSS shall ensure that behavioral health providers are adhering to the following travel limitations:
    a. Provider travel mileage may not be billed separately except when it exceeds 25 miles,
    b. When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip, and
    c. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.
19. Providers shall not bill for travel for missed appointments. This includes time spent conducting outreach without successfully finding the Member and for time spent driving to do a home visit and the Member is not home.

B. COVERED BEHAVIORAL HEALTH SERVICES

1. The AdSS shall cover the following treatment services under the behavioral health benefit:
    a. Assessment, non-court ordered evaluation, and screening services when provided by individuals, who are qualified BHPs or BHTs, supervised by BHPs when clinically appropriate. Refer to AMPM 320-U for Court-Ordered Evaluation responsibilities.
    b. Behavioral health counseling and therapy when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate.
    c. Psychophysiological therapy and biofeedback when provided by qualified BHPs.
2. The AdSS shall cover the following Rehabilitation Services:
    a. Skills training and development and psychosocial rehabilitation living skills training.
        i. Skills training includes teaching independent living, social, and communication skills to Members and/or their families.

ii. Services may be provided to a Member, a group of individuals or their families with the Member(s) present.

iii. Skills training and development and psychosocial rehabilitation living skills training is provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or qualified BHT.

iv. More than one provider agency may bill for skills training and development services provided to a Member at the same time if indicated by the Member's clinical needs as identified in their Service Plan.

b. Cognitive rehabilitation

i. Provided by qualified BHP's to facilitate recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible.

ii. Goals of cognitive rehabilitation include:

1) Relearning of targeted mental abilities,

2) Strengthening of intact functions,

3) Relearning of social interaction skills,

4) Substitution of new skills to replace lost functioning, and

5) Controlling the emotional aspects of one's functioning.

iii. Training is done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects.

iv. Training is provided one-on-one and is highly customized to each individual's strengths, skills, and needs.

c. Health promotion

i. Provided to educate and train about health-related topics to an individual or a group of people and/or their families.

ii. Presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as:

1) the nature of an illness,
2) relapse and symptom management,
3) medication management,
4) stress management,
5) safe sex practices,
6) Human Immunodeficiency Virus (HIV) education,
7) parenting skills education, and
8) Healthy lifestyles.

iii. DUI health promotion education and training approved by Arizona Department of Health Services (ADHS), Division of Licensing Services (DLS),

iv. More than one provider agency may bill for health promotion provided to a Member at the same time if

indicated by the Member's clinical needs as identified in their Service Plan.

d. Pre-Vocational Psychoeducational Services and ongoing support to maintain employment, post-vocational services, or job coaching that are designed to:

i. Assist Members to choose, acquire, and maintain employment or other meaningful community activity as specified in AMPM Policy 1240-J.

ii. Prepare Members to engage in meaningful work-related activities, such as full- or part-time, competitive employment.

iii. Provided individually or in a group setting, but not telephonically and may include, but are not limited to, the following:

1) Career or educational counseling;

2) Job training, assistance in the use of educational resources necessary to obtain employment;

3) Attendance to/Vocational Rehabilitation Orientations;

4) Attendance to job fairs;

5) Assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills; ;

6) Professional decorum; and

7) Time management.

iv. Provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) DES-RSA, which is required to be the primary payer for Title XIX/XXI eligible individuals. The following services are not TXIX/TXXI covered treatment services:

1) Rehabilitative employment support assessments when available through the

federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration,

2) Preparation of a report of a Member's psychiatric status for primary use with a court.

e. Ongoing support to maintain employment services

i. Post vocational services, often called job coaching, enable Members to maintain their current employment.

ii. Utilized when assisting employed Members with services traditionally used as pre-vocational in order to gain skills for promotional employment or alternative employment.

iii. Provided individually or in a group setting, as well as telephonically.

iv. Services may include, but are not limited to, the following:

1) Monitoring and supervision,

2) Assistance in performing job tasks, and

3) Supportive counseling.

f. Pre-vocational services and ongoing support to maintain employment to include the following:

i. Provided using tools, strategies, and materials which meet the Member's support needs.

ii. Services are tailored to support Members in a variety of settings.

iii. Service may be utilized for exploring strengths and interests when a Member is not ready to identify an educational or employment goal.

iv. Provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or Qualified BHTs.

v. Billed by more than one provider agency for services provided to a Member at the same time, if indicated by the Member's clinical needs as identified in their Service Plan.

vi. For Community Service Agencies, see AMPM Policy 965 for further detail on service standards and provider qualifications for this service.

3. The AdSS shall cover medical services ordered within the scope of practice by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a Member's symptoms and improve or maintain functioning.

   a. For covered medications, the AdSS shall maintain its own formulary to meet the unique needs of Members with behavioral health disorders. At a minimum the AdSS' formulary shall include all of the medications listed on the AHCCCS formulary per AMPM Policy 310-V.

   b. Laboratory, radiology, and medical imaging services shall be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice for screening, diagnosis or monitoring of a behavioral health condition.

i. Laboratory services shall be provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, with the exception of specimen collections in a medical practitioner's office.

c. Medical management services shall be provided within the scope of practice by a licensed physician, nurse practitioner, physician assistant or nurse to an individual as part of their medical visit for ongoing treatment purposes. Medical management includes:

1) Review of medication(s) side effects, and

2) The adjustment of the type and dosage of prescribed medications.

d. Outpatient Electroconvulsive Therapy (ECT) and outpatient Transcranial Magnetic Stimulation (TMS) performed by a physician within their scope of practice.

4. The AdSS shall cover support services to facilitate the delivery of or enhance the benefit received from other Behavioral Health Services.
5. The AdSS shall require that support services be provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs.
6. The AdSS shall classify support services into the following subcategories:
    a. Provider case management as specified in AMPM 570.
    b. Personal care services which involve the provision of support activities that assist an individual in carrying out daily living activities.
        i. May be provided in an unlicensed setting such as a Member's own home or community setting.
        ii. Parents including natural parent, adoptive parent and stepparent may be eligible to provide personal care services if the Member receiving services is 21 years

or older and the parent is not the Member's legal guardian.

iii. Personal care services provided by a Member's spouse are not covered

iv. More than one provider agency may bill for personal care services provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

c. Home care training or Family Support services which are directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the Member in the home and community.

i. Family Support Services involve activities to assist the family to adjust to the Member's illness, develop skills to effectively interact or guide the Member, understand the causes and treatment of behavioral

health issues, and understand and effectively utilize the healthcare system.

ii. More than one provider agency may bill for family support provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

d. Peer Services which provide intentional partnerships based on shared lived experiences of living with behavioral health, intellectual or developmental disability, and/or substance use disorders, to provide social and personal support.

e. Therapeutic Foster Care (TFC) for Children as specified in AMPM Policy 320-W and Adult Behavioral Health Therapeutic Home as specified in AMPM Policy 320-X.

f. Unskilled respite care (respite) which provides an interval of rest or relief to a Family Member or other individual caring for the Member receiving Behavioral Health Services

and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

i. The availability and use of informal supports and other community resources to meet the caregiver's respite needs shall be evaluated by the assigned Support Coordinator, and Provider Case Manager authorizing the respite services, in addition to formal respite services.

ii. Respite services are limited to 600 hours per year (October 1 through September 30) per person and are inclusive of both AdSS behavioral health and Division ALTCS respite care.

iii. Respite may include a range of activities to meet the social, emotional, and physical needs of the Member during the respite period. These services may be provided on a short-term basis, a few hours or for longer periods of time involving overnight stays.

iv. Respite services can be planned or unplanned. If unplanned respite is needed, the AdSS shall ensure the behavioral health provider assess the situation with the caregiver and recommends the appropriate setting for respite.

v. Community Service Agencies cannot provide respite services.

vi. Respite services may be provided in a variety of settings:

1) Habilitation Provider settings,

2) Outpatient Clinic,

3) Adult Therapeutic Foster Care,

4) Behavioral Health Respite Homes,

5) Behavioral Health Residential Facilities,

6) Member's home, and

7) Community settings..

vii. A Member's Planning Team shall consider the appropriateness of the setting in which the recipient receives respite services:

1) When respite services are provided in a home setting, household routines and preferences shall be respected and maintained when possible.

2) The respite provider shall receive orientation from the family/caregiver regarding the Member's needs and the Service Plan.

3) Respite services, including the goals, setting, frequency, duration, and intensity of the service shall be defined in the Member's Service Plan.

4) Respite services are not a substitute for other covered services.

5) Summer day camps, day care, or other ongoing, structured activity programs are not

respite unless they meet the definition or criteria of respite services and the provider qualifications.

viii. Members who are parents and receive Behavioral Health Services may receive necessary respite services for their non-enrolled children as indicated in their Service Plan, and

ix. Non-enrolled siblings of a child Member receiving respite services are not eligible for behavioral health respite benefits.

g. Permanent Supportive Housing (PSH) Support Services which provide flexible housing-based supports targeted towards individuals most at need based upon their health condition, housing status, and current or potential system costs.

i. Scope, frequency, delivery, and setting should be individualized to the Member's need, circumstances, and choice.

ii. Services shall be consistent with PSH evidence-based standard, nationally recognized or identified best practice.

iii. Services shall be voluntary to the Member.

iv. Staff providing these services shall be knowledgeable and provide services consistent with evidence-based practice for PSH models.

7. The AdSS shall cover intensive outpatient and behavioral health day programs including the following:

a. Intensive outpatient treatment programs

i. Structured non-residential treatment programs that address mental health and substance use disorders through a combination of individual, group and family counseling and therapy and educational groups but do not require detoxification.

b. Behavioral Health Day Programs

i. Regularly scheduled program of individual, group or family services related to the Member's treatment

plan designed to improve the ability of the person to function in the community and may include the following rehabilitative and support services:

1) Skills training and development,
2) Behavioral health prevention/promotion,
3) Medication training and support,
4) Pre-vocational services and ongoing support to maintain employment,
5) Peer and Recovery Support, and
6) Home care training or Family Support.

ii. May be provided by either ADHS DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies (CSA).

iii. Staff members that deliver specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

iv. BHT's shall supervise behavioral health treatment and day programs provided by a CSA.

c. Therapeutic behavioral health day programs

i. Regularly scheduled program of active treatment modalities which may include services such as:

1) Individual, group and/or Family behavioral health counseling and therapy;

2) Skills training and development;

3) Behavioral health prevention/promotion;

4) Medication training and support;

5) Pre-vocational services and ongoing support to maintain employment;

6) Home care training or Family support;

7) Medication monitoring;

8) Case management;

9) Peer and Recovery Support; and

10) Medical monitoring.

ii. Provided by an appropriately licensed ADHS DLS Outpatient Treatment Center and as specified with applicable service requirements set forth in A.A.C. R9-10-1000.

iii. Under the direction of a BHP.

iv. Staff members that deliver specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

d. Community Psychiatric Supportive Treatment Program

i. Provide regularly scheduled program of active treatment modalities, including medical interventions, in a group setting and may include:

1) Individual, group or family behavioral health counseling and therapy;

2) Skills training and development;

3) Behavioral health prevention/promotion;

4) Medication training and support;

5) Ongoing support to maintain employment;

6) Prevocational services;

7) Home care training or Family support;

8) Peer and Recovery Support; and

9) Other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

ii. Services are provided by an appropriately licensed ADHS DLS behavioral health agency and as specified with applicable service requirements set forth in A.A.C. R9-10-1000.

iii. Programs shall be under the direction of a licensed physician, nurse practitioner, or physician assistant.

iv. Staff members that deliver specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

8. The AdSS shall cover Behavioral Health Residential Facility Services as specified in AMPM Policy 320-V.
9. The AdSS shall cover Behavior Analysis services as specified in AMPM Policy 320-S.
10. The AdSS shall ensure timely follow up and care coordination for Members after receiving crisis services as specified in AMPM Policy 590.
11. The AdSS shall cover Inpatient Services provided by ADHS licensed inpatient facilities in accordance with A.A.C. R9-10-300 which provides a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services.
12. The AdSS shall ensure inpatient services are further classified into the following subcategories:
    a. Hospital services that provide continuous treatment with 24-hour nursing supervision and physicians on site and on call that includes:
        i. General psychiatric care,

ii. Medical detoxification,

iii. Forensic services in a general hospital, a general hospital with a distinct psychiatric unit, or

iv. A freestanding psychiatric facility.

1) General and freestanding hospitals that provide services to Members if the hospital:

a) Meets the requirements of 42 CFR 440.10 and CFR Title 42, Chapter IV, Subchapter G, Part 482, and

b) Is licensed pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. R9-10-200 and A.A.C. Title 9, Chapter 10.

2) Prior authorization is required for Bed Hold or Therapeutic Leave.

a) For Members age 21 and older, therapeutic leave may not exceed nine days, and Bed Hold bed hold days may not exceed 12 days, per contract year,

b) For Members under 21 years of age, total therapeutic leave or Bed Hold days may not exceed 21 days per contract year.

b. Behavioral Health Inpatient Facilities (BHIF) which provide continuous treatment to a person who is experiencing acute and significant behavioral health symptoms. BHIF's may provide observation or stabilization services and child and adolescent residential treatment services, in addition to other behavioral health or physical health services, as identified under their licensure capacity.

i. Observation or Stabilization Services

1) Services in addition to 24-hour nursing supervision and physicians on site or on call include:

a) Emergency reception;

b) Screening;

c) Assessment;

d) Crisis intervention and stabilization;

e) Counseling; and

f) Referral to appropriate level of services and care. Refer to the section on facility-based crisis intervention services for more information (A.A.C. R9-10-1016),

2) Services, within a BHIF, shall be provided according to the requirements in A.A.C. R9-10-1012 for outpatient treatment centers.

3) Facilities shall meet the requirements for reporting and monitoring the use of Seclusion and Restraint (S&R) as specified in Arizona Administrative Code. The use of S&R shall only be used to the extent permitted by and in compliance with A.A.C. R9-21-204 and A.A.C. R9-10-316.

ii. Partial Hospitalization programs (PHP) include intensive therapeutic treatment and must be

targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

1) May include the following rehabilitative and support services:

a) Individual therapy,

b) Group and family therapy, and

c) Medication management.

2) PHP service shall be provided by an appropriately licensed ADHS DLS Outpatient Treatment Center.

3) Staff who deliver the specific services shall meet the individual provider qualifications.

iii. Residential treatment services shall be accredited and meet the requirements for S&R specified set forth in 9 A.A.C. R9-10-316 and in accordance with 42 CFR 441 and 42 CFR 483 if the facility has been authorized by ADHS DLS to provide S&R.

1) Child and adolescent residential treatment services shall be provided by a BHIF to an individual who is under 18 years of age or under 21 years of age and meets the criteria in A.A.C. R9-10-318.

Signature of Chief Medical Officer: Anthony Dekker (Jul 26, 2023 14:47 PDT)

Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

Provider Travel

Provider travel is the cost associated with certain provider types traveling to provide a covered behavioral health service. This is different from transportation, which is provided to take a member to and from a covered behavioral health service. Certain Behavioral Health Professionals are eligible to bill for provider travel services, as outlined below.

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service. In these circumstances, providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160. The following examples demonstrate when to bill for additional miles:

- If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately.
- If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the

first 25 miles of provider travel are included in the rate, but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).

- If Provider C travels to multiple out-of-office settings (in succession), he/she shall calculate provider travel mileage by segment. For example:

  First segment = 15 miles, 0 travel miles are billed,

  Second segment = 35 miles, 10 travel miles are billed,

  Third segment = 30 miles, 5 travel miles are billed, and

  Total travel miles billed = 15 miles are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

Providers may not bill for travel for missed appointments.

Provider Travel Limitations

If a Behavioral Health Professional, Behavioral Health Technician, or Behavioral Health Paraprofessional travels to provide case management services, or provider type 85, 86, 87, or A4 travels to provide services, to a

client and the client misses the appointment, the intended service may not be billed. Additionally, providers may not bill for travel for missed appointments. This applies for time spent conducting outreach without successfully finding the member and for time spent driving to do a home visit and the member is not home.

Skills training and development and psychosocial rehabilitation living skills training

Skills training includes teaching independent living, social, and communication skills to members and/or their families. Skills training and development and psychosocial rehabilitation living skills training is teaching independent living, social, and communication skills to members and/or their families. Examples of areas that may be addressed include self-care, household management, relationships, avoidance of exploitation, budgeting, recreation, development of social support networks, and use of individuals or their families with the member(s) present.

Cognitive rehabilitation

Cognitive rehabilitation is the facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible, goals of cognitive rehabilitation include relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, and training in the use of assistive technology, and anger management. Goals of cognitive rehabilitation include relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning.

Health Promotion

Education and training about health-related topics that can be provided in single or multiple sessions shall be provided to an individual or a group of people and/or their families.

Psychoeducational Services (pre-vocational services) and ongoing support to maintain employment (post-vocational services, or job coaching)

Psychoeducational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) DES-RSA, which is required to be the primary payer for Title XIX/XXI eligible individuals. The following services are not TXIX/TXXI covered treatment services: Rehabilitative employment support assessments when available through the federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration, and preparation of a report of a member's psychiatric status for primary use with a court. Designed to assist members to choose, acquire, and maintain employment or other meaningful community activity (e.g. volunteer work). Psychoeducational Services are pre-vocational services that prepare members to engage in meaningful work-related activities, such as full- or part-time, competitive employment.

Provider Case Management

Provider case management is a supportive service provided to improve treatment outcomes. Examples of case management activities to meet member's Service Plan goals include:

- Assistance in maintaining, monitoring and modifying behavioral health services
- Assistance in finding necessary resources other than behavioral health services
- Coordination of care with the member's healthcare providers, Family, community resources, and other involved supports including educational, social, judicial, community and other State agencies,
- Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services, and Family counseling).
- Assisting members in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.

SOAR activities may include face to face meetings with member, phone contact with member, and face to face and phone contact with records and data sources (e.g. jail staff, hospitals, treatment providers, schools, Disability Determination Services, Social Security Administration, physicians).

- SOAR services shall only be provided by staff who have been certified in SOAR through SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include completion of SOAR paperwork without member present, copying or faxing paperwork, assisting members with applying for benefits without using the SOAR approach, and email.

Personal care services

Assisting an individual in carrying out activities of daily living such as but not limited to bathing, shopping, dressing, and other activities for living in a community.

Unskilled Respite Care (Respite)

Short term behavioral health services or general supervision that provides an interval of rest or relief to a Family Member or other individual caring for the member receiving behavioral health services as authorized under the Section 1115 Waiver Demonstration and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

310-C BREAST RECONSTRUCTION AFTER MASTECTOMY

EFFECTIVE DATE: October 26, 2022
REFERENCES: 42 U.S. Code § 300gg-52, A.A.C. R9-22-205

PURPOSE

This policy describes covered breast reconstruction surgery services following a mastectomy for ALTCS members. This policy applies to DDD's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Contralateral" means relating to or denoting the side of the body opposite to that on which a particular structure or condition occurs.

POLICY

A. COVERED SERVICES

1. The AdSS shall cover breast reconstructive surgery post-mastectomy per 42 U.S. Code § 300gg-52.
2. The AdSS shall cover reconstructive breast surgery of the unaffected contralateral breast following mastectomy if required to achieve relative symmetry with the reconstructed affected breast.

3. The AdSS shall cover breast reconstruction surgery either immediately following the mastectomy or after the breast reconstruction, based on the choice of the member.
4. The AdSS shall cover medically necessary breast implant removal when the original implant was the result of a medically necessary mastectomy.
5. The AdSS shall cover an external prosthesis, including a surgical brassiere, for DDD Long Term Care members who choose not to have breast reconstruction post-mastectomy, or who choose to delay breast reconstruction until a later time.

B. LIMITATIONS

1. The AdSS shall not cover services provided solely for cosmetic purposes, per A.A.C. R9-22-205. If a member has had a breast implant procedure for cosmetic purposes, (i.e., augmentation), not related to a mastectomy, medically necessary removal of the implant is covered, but implant replacement is not covered.

Signature of Chief Medical Officer: Anthony Dekker (Oct 19, 2022 10:36 PDT)
Anthony Dekker, D.O.

310-D1 EMERGENT DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

REVISION DATE: 4/26/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907, A.R.S. § 14-5101; A.A.C. R9-22-207; AMPM 310-D2

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and establishes requirements for the provision of medically necessary dental services for Members of the Division of Developmental Disabilities (Division) who are age 21 and older.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection due to pathology or trauma.
2. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,

c. A dental therapist as defined in A.R.S. §32-1201,

d. A dental hygienist as defined in A.R.S. §32-1201,

e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental

disability who is a member or an applicant for whom no guardian has been appointed.

7. "Simple Restoration" means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns.

POLICY

A. GENERAL COVERED DENTAL SERVICES

1. The AdSS shall cover the following dental services provided by a licensed dentist for Members who are 21 years of age or older:
    a. Emergency dental services up to $1,000 per Member per contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
    b. Medical and surgical services furnished by a dentist when:
        i. The services may be performed under state law either by a physician or by a dentist, and
        ii. The services would be considered a Physician Service if furnished by a physician.
2. The AdSS shall cover services related to treatment of the following medical conditions:

a. Acute pain,

b. Infection, or

c. Fracture of the jaw.

3. The AdSS shall ensure covered services include:

a. Limited problem focused examination of the oral cavity,

b. Required radiographs,

c. Complex oral surgical procedures such as treatment of maxillofacial fractures,

d. Administration of an appropriate anesthesia, and

e. Prescription of pain medication and antibiotics.

4. The AdSS shall not cover the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) except for reduction of trauma, under the emergent dental benefit.

5. The AdSS shall not subject services outlined in subsection (3) and (4) of this section to the $1,000 adult emergency dental limit.

6. The AdSS shall cover the following limited dental services for Members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation:
   a. Elimination of oral infections and the treatment of oral disease, which include:
      i. Dental cleanings,
      ii. Treatment of periodontal disease,
      iii. Medically necessary extractions, and
      iv. Provision of Simple Restorations.
7. The AdSS shall cover services outlined in subsection (6) of this section only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.
8. The AdSS shall cover prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.

9. The AdSS shall not subject services outlined in subsection (3), (4), (6), and (8) of this section to the $1,000 adult emergency dental limit.

10. The AdSS shall cover cleanings for Members who are in an inpatient hospital setting and experiencing the following:

    a. Placed on a ventilator, or

    b. Physically unable to perform oral hygiene.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR MEMBERS AGE 21 AND OLDER

1. The AdSS shall cover medically necessary emergency dental care and extractions for Members age 21 years and older who meet the criteria for a Dental Emergency.

2. The AdSS shall cover the following services and procedures as emergency dental services:

    a. Emergency oral diagnostic examination;

    b. Radiographs and laboratory services, limited to the symptomatic teeth;

c. Composite resin due to recent tooth fracture for anterior teeth;

d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;

e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;

f. Pulp cap, direct or indirect plus filling;

g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative or sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection including:

i. Periapical and periodontal infections, and

ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. The AdSS shall cover follow-up procedures needed to stabilize teeth due to the emergency services and subject to the $1,000 limit.

C. ADULT EMERGENCY DENTAL SERVICES LIMITATIONS FOR MEMBERS AGE 21 YEARS AND OLDER

1. The AdSS shall not cover the following adult dental services:

a. Maxillofacial dental services provided by a dentist, except to the extent prescribed for the reduction of trauma,

including reconstruction of regions of the maxilla and mandible;

b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;

c. Routine restorative procedures and routine root canal therapy;

d. Treatment for the prevention of pulpal death and imminent tooth loss, except:

i. Non-cast fillings,

ii. Crowns constructed from pre-formed stainless steel,

iii. Pulp caps, and

iv. Pulpotomies only for the tooth causing pain or in the presence of active infection.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. AdSS and FFS PROGRAM RESPONSIBILITIES

1. The AdSS shall provide the following:

a. Coordination of covered dental services for enrolled Division Members;

b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to dentist(s) when the Member is determined to need emergency dental services, or Members may self- refer to a dentist when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted dentist(s).

2. The AdSS shall ensure the annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers:

a. Between one AdSS to another, or

b. Between Fee-For-Service and an AdSS.

3. The AdSS shall ensure dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
4. The AdSS or Tribal Case Manager shall notify the accepting entity regarding the current balance of the dental benefit.
5. The relinquishing AdSS shall use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
    a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;
    b. The Member is not permitted to carry-over unused benefit from one year to the next; and
    c. A year begins on October 1st and ends September 30th.

6. The AdSS shall not require prior authorization for emergency dental services for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The AdSS shall cover emergency dental services of $1,000 per contract year for Division Members age 21 years and older. Billing of Division Members for emergency dental services in excess of the $1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute Members, and A.A.C. R9-28-701.10 for ALTCS Members.
2. The AdSS shall ensure providers who bill Members for emergency dental services exceeding the $1,000 limit conduct the following:
    a. The provider must first inform the Member in a way they understand, that the requested dental service exceeds the $1,000 limit and is not covered by the Division,
    b. The provider must furnish the Member with a document to be signed in advance of the service, stating that the

Member understands that the dental service will not be fully paid by the Division,

c. The document shall contain information describing the type of service to be provided and the charge for the service.

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division, and

e. The Member must sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. The AdSS shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

   a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

      i. An ambulatory service center, or

      ii. An outpatient hospital.

   b. Anesthesia is required as part of the emergency service.

2. The AdSS shall ensure dentists performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 emergency dental limit.
3. The AdSS shall ensure Physicians performing GA on Members for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. The AdSS shall ensure providers complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.
2. The AdSS shall ensure Informed Consents for oral health treatment include the following:
    a. A written consent for examination or any treatment measure, which does not include an irreversible procedure;
    b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment;
    c. A separate written consent is completed for the following:

i. Irreversible procedures,

ii. Invasive procedures,

iii. Dental fillings or

iv. Pulpotomies.

d. Consent is used in a manner that protects the Member and is easily understood by the:

i. Member,

ii. Guardian, or

iii. Responsible Person.

e. A written treatment plan must be reviewed and signed by the Responsible Person, with the Member;

f. Consents and treatment plans must be:

i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age, or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan; and

h. Extends to all Contractor mobile unit providers.

3. The AdSS shall ensure completed consents and treatment plans are maintained in the Members chart and are subject to audit.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 15:01 PDT)
Anthony Dekker, D.O.

310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT ROUTINE DENTAL SERVICES

REVISION DATE: 4/26/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM 310-D2

PURPOSE

This policy applies to the Administrative Services Subcontractors (AdSS) and establishes requirements regarding the provision of medically necessary routine dental services for Members in the Arizona Long Term Care Program (ALTCS).

DEFINITIONS

1. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,

e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

2. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall cover the following medically necessary dental benefits up to $1,000 per Member per contract year for ALTCS Members age 21 or older in accordance with A.R.S. § 36-2939:
   a. Diagnostic care,
   b. Therapeutic care, and
   c. Preventative care to include dentures.
2. The AdSS shall refer to AMPM 430 for dental services for Members under the age of 21.
3. The AdSS shall cover emergent services for Members as specified in AMPM 310-D1. These services do not count towards the ALTCS $1,000 limit.

B. AdSS RESPONSIBILITIES

1. The AdSS shall ensure the following is provided:
   a. Coordination of covered dental services for enrolled Members;
   b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);

c. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

d. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The AdSS shall ensure primary care providers initiate Member referrals to dentist(s) when the Member is determined to be in need of dental services. Members may also self-refer to a dentist when in need of dental services.

3. The AdSS shall ensure the annual dental benefit limit remains with the Member if the Member transfers to the following:

   a. Between one AdSS to another, or

   b. Between Fee-For-Service and an AdSS.

4. The transferring AdSS shall notify the receiving AdSS regarding the current balance of the Member's dental benefit.

5. The AdSS shall utilize the ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9, for reporting any dental benefit balance.

6. The AdSS shall ensure dental services provided to American Indian/Alaska Native Members within an Indian Health Service (IHS) or 638 Tribal Facility are not subject to the ALTCS dental benefit $1,000 limit.
7. The AdSS shall ensure the Member is aware they are not permitted to carry-over unused benefit from one contract year to the next.
8. The AdSS shall utilize the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies to ensure frequency limitations and services that require prior authorization are met as specified in AMPM 431.

C. FACILITY AND ANESTHESIA CHARGES

1. The AdSS shall ensure facility and anesthesia charges are subject to the $1,000 routine dental limit when:
    a. A Member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in:

i. An ambulatory surgery center, or

ii. An outpatient hospital.

b. Anesthesia is required as part of the routine service.

2. The AdSS shall ensure dentists performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 limit.

3. The AdSS shall ensure Physicians performing GA on a patient for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 limit.

D. INFORMED CONSENT

1. The AdSS shall ensure providers complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.

2. The AdSS shall ensure Informed Consents for oral health treatment include the following:

a. A written Consent for examination or any treatment measure, which does not include an irreversible procedure,

b. The Consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment,

c. A separate written Consent is completed for:

   i. Irreversible procedures,

   ii. Invasive procedures,

   iii. Dental fillings, or

   iv. Pulpotomies.

d. Consent is used in a manner that protects the Member and is easily understood by the:

   i. Member,

   ii. Guardian, or

   iii. Responsible Person.

e. A written treatment plan must be reviewed and signed by the Responsible Person with the Member,

f. Consents and treatment plans must be:

   i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age, or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

3. The AdSS shall ensure completed consents and treatment plans are maintained in the Members' chart and are subject to audit.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The AdSS shall ensure medically necessary services are provided within the $1,000 dental benefit allowable amount.

2. The AdSS shall ensure services are provided as set forth in A.A.C. R9-28-701(10) and R9-22-702, if medically necessary services are greater than $1,000.

3. The AdSS shall ensure the following notification when the provider informs the Member that the dental service requested is not covered and exceeds the $1,000 limit:
   a. Verbally,
   b. In writing, and
   c. In the Member's primary language.
4. The AdSS shall ensure the following if the Member agrees to pursue the receipt of services:
   a. The provider shall supply the Member a document describing the service and the anticipated cost of the service, and
   b. Prior to service delivery, the Member must sign and date a document indicating that they understand they will be responsible for the cost of the service to the extent that it exceeds the $1,000 limit.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 14:30 PDT)
Anthony Dekker, D.O.

310–G EYE EXAMINATIONS/OPTOMETRY SERVICES

REVISION DATE: 10/1/2021

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Eye and optometric services are covered for members eligible for ALTCS when provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Emergency eye care which meets the definition of an emergency medical condition is covered for all members eligible for ALTCS. For members who are 21 years of age or older treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, and for adults when medically necessary following cataract removal. Refer to Division Medical Policy Manual, Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all members eligible for ALTCS. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

A. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

B. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading

C. For the Division's American Indian Health Plan (Fee-For-Service) members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions, or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

A. Phacogenic Glaucoma

B. Phacogenic Uveitis.

310-I HOME HEALTH SERVICES

REVISION DATE: 10/1/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-1201 et seq.
This policy applies to:

- The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS) and Qualified Vendors
- Fee-For-Services (FFS) Programs, including Tribal Arizona Long Term Care System (ALTCS), the DDD Tribal Health Program (THP), and all FFS populations.

This policy does not apply to Federal Emergency Services (FES); for information regarding FES, see Division Medical Manual Chapter 1100. This policy establishes requirements regarding Home Health Services.

Definitions

A. Home Health Agency - A public or private agency or organization, or part of an agency or organization, that is licensed by the state and meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28 [42 CFR 440.70].

B. Home Health Services - Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70, when provided to a member at his/her place of residence and on his/her physician's orders as part of a written plan of care [42 CFR 440.70].

C. Place of Residence - A member's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), except for home health services in an ICF/IID facility that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a beneficiary in an intermediate care facility for Individuals with Intellectual Disabilities during an acute illness to avoid the beneficiary's transfer to a nursing facility.

Policy

The Division covers medically necessary home health services provided in the member's place of residence as a cost-effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary medical equipment, appliances and supplies, and therapy services for Division members. Home health services are covered when ordered by the member's treating physician.

ALTCS covers home health services for members receiving home and community based services. Refer to Division Medical Policy 1240-G for additional information.

A. Home Health Nursing and Home Health Aide Services

Home health nursing and home health aide services are provided on an intermittent basis as ordered by a treating physician.

B. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

Physical therapy, occupational therapy, speech therapy, and audiology services provided by a licensed home health agency are covered for members as specified in Division Medical Policy 310-X.

C. Medical Equipment, Appliances and Supplies

Medical equipment, appliances, and supplies provided by a licensed home health agency are covered for members.

D. Face-to-Face Encounter Requirements

1. Face-to-face encounter requirements apply to FFS only.

2. For initiation of home health services, a face-to-face encounter between the member and practitioner that relates to the primary reason the individual requires home health services is required within no more than 90 days before or within 30 days after start of services.

3. The face-to-face encounter must be conducted by one of the following:

   a. The ordering physician

   b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law

   c. A certified nurse midwife as authorized by state law

   d. A physician assistant under the supervision of the ordering physician, or

   e. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The non-physician practitioner specified above who performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician.

5. The clinical findings must be incorporated into a written or electronic document in the member's' record.

6. Regardless of which practitioner performs the face-to-face encounter related to the primary reason that the individual requires home health services, the physician responsible for ordering the services must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes.

   The face-to-face encounter may occur through telehealth.

310–J HOSPICE SERVICES

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, Arizona's Section 115(a) Medicaid Demonstration Extension.

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member's own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital

B. Nursing care institution

C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Continuous home care - hospice provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or an alternative residential setting. Continuous home care is not available to members residing in a Nursing Facility (NF) Medicaid certified bed.

B. Inpatient respite care - services provided in an inpatient setting, such as an NF, on a short-term basis to relieve family members or other caregivers who provide care to

members eligible for hospice who have elected to receive hospice care and who reside in their own home or, home and community based (HCB) alternative residential setting.

C. General inpatient care - services provided, in an inpatient setting such as a hospital, to members eligible for hospice who have elected to receive hospice. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be performed in another setting.

D. Period of crisis - a period in which the hospice-eligible member requires continuous care to achieve palliation or management of acute medical symptoms.

E. Routine home care - short-term, intermittent hospice including skilled nursing, home health aide and/or homemaker services provided to a hospice-eligible member in his or her own home or an alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The member eligible for hospice must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in an NF Medicaid certified bed.

Amount, Duration and Scope

Prior to the member receiving hospice services, the physician must provide, to the Administrative Services Subcontractor (AdSS), certification stating that the member's prognosis is terminal with the member's life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician certifications are completed.

The physician certification is permitted for two 90-day periods; thereafter, an unlimited number of physician certifications for 60-day periods are permitted.

The AdSS must notify the Division's Health Care Services within five business days of any approval or denial of Hospice services. The AdSS must also notify the Support Coordinator that a referral has been made.

State licensure standards for hospice care require providers to include skilled nursing, respite, and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services, available as necessary to meet the member's needs. The following components are included in hospice service reimbursement, if they are provided in approved settings:

A. Bereavement services, including social and emotional support provided by the hospice provider, to the member's family both before and up to twelve months following the death of that member

B. Continuous home care (as specified in this policy), which may be provided only during a period of crisis

C. Dietary services, which include a nutritional evaluation and dietary counseling when necessary

D. Home health aide services

E. Homemaker services

F. Nursing services provided by or under the supervision of a registered nurse

G. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field, and who is appropriately licensed or certified

H. Hospice respite care services that are provided on an occasional basis, not to exceed more than five consecutive days at a time

(Hospice respite care services may not be provided when the member is residing in a nursing facility or is receiving services in an inpatient setting indicated above.)

I. Routine home care, as specified in the definition of hospice services

J. Social services provided by a qualified social worker

K. Therapies that include physical, occupational, respiratory, speech, music, and recreational therapy

L. Twenty-four hour on-call availability to provide services such as reassurance, information and referral, for members and their family members or caretakers

M. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee

(Under 42 CFR 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services.)

N. Medical supplies, appliances, and equipment, and pharmaceuticals used in relationship to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

310-L HYSTERECTOMY

EFFECTIVE DATE: February 7, 2024
REFERENCES: 42 CFR 441.250 et seq, 42 CFR 441.251, 42 CFR 441.255, AMPM 820.

PURPOSE

This Policy establishes the requirements for coverage of Hysterectomy services in accordance with 42 CFR 441.250 et seq for Members who seek to obtain a medically necessary Hysterectomy. This policy applies to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus as specified in 42 CFR 441.251.

2. "Initial Medical Acknowledgement" means documentation of the Member's understanding prior to surgery, the procedure will render them sterile.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor

with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

5. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure AdSS Members are receiving medically appropriate and high quality care.

6. "Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing as specified in 42 CFR 441.251.

POLICY

A. CONDITIONS WHEN A HYSTERECTOMY IS COVERED IF DEEMED MEDICALLY NECESSARY

1. The AdSS shall cover a Hysterectomy for the following conditions

when medically necessary:

a. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding, when medical and surgical therapy has failed, and childbearing is no longer a consideration;

b. Endometriosis, with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy; or

c. Uterine Prolapse, when childbearing is no longer a consideration and for whom non-operative or surgical correction, suspension or repair, will not provide the Member adequate relief.

B. CONDITIONS WHERE MEDICAL OR SURGICAL INTERVENTION IS NOT REQUIRED PRIOR TO HYSTERECTOMY

1. The AdSS shall cover medically necessary Hysterectomy services without prior trial of medical or surgical intervention in the following cases:

a. Invasive carcinoma of the cervix;

b. Ovarian carcinoma;

c. Endometrial carcinoma;

d. Carcinoma of the fallopian tube;

e. Malignant gestational trophoblastic disease;

f. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy;

g. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption; or

h. Other potentially life threatening conditions where removal of the reproductive organs is necessary and considered the standard of care.

2. The AdSS shall require the provider to complete AMPM Attachment 820-A prior to performing Hysterectomy procedures.

C. MEDICAL ACKNOWLEDGEMENT AND DOCUMENTATION

1. The AdSS shall require providers comply with the following requirements prior to performing the Hysterectomy:

a. Inform the Responsible Person both orally, in the Member's medical records and in AMPM Attachment 820-A that the Hysterectomy will render the Member incapable of reproducing, resulting in sterility;

b. Obtain from the Responsible Person a signed, and dated written acknowledgment stating that the information in AMPM Attachment 820-A has been received and that the individual has been informed and understands that the Hysterectomy will result in sterility.

2. The AdSS shall require a signed, and dated written acknowledgment is kept in the Member's medical record maintained by the Primary Care Provider (PCP) if enrolled with an AdSS.

3. The AdSS shall require providers use AMPM Attachment 820-A as specified in AMPM 820.

D. EXCEPTIONS FROM INITIAL MEDICAL ACKNOWLEDGEMENT

1. The AdSS shall not require the physician performing the

Hysterectomy to obtain Initial Medical Acknowledgment in either of the following situations:

a. The Member was already sterile before the Hysterectomy.

   i. In this instance the physician shall certify in writing that the Member was already sterile at the time of the Hysterectomy and specify the cause of sterility.

   ii. Documentation shall include the specific tests and test results conducted to determine sterility if the cause of sterility is unknown; or

b. The Member requires a Hysterectomy because of a life-threatening emergency situation in which the physician determines that Initial Medical Acknowledgement is not possible. In this circumstance, the physician shall document in the Member's medical records and in AMPM Attachment 820-A that the Hysterectomy was performed under a life-threatening emergency situation in which the physician determined that Initial Medical Acknowledgement was not possible.

2. The physician shall include a description of the nature of the emergency in the Member's medical record and when AMPM Attachment 820-A is submitted to the AdSS.

E. LIMITATIONS

1. The AdSS shall not cover a Hysterectomy if:
   a. It is performed solely to render the individual permanently incapable of reproducing; or
   b. There was more than one purpose to the procedure, and the procedure would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

F. SECOND LEVEL REVIEW

1. The AdSS shall:
   a. Submit all approvals or denials for Hysterectomies to the Division for Second Level Review prior to the completion of the procedure, except in the event of a life-threatening

emergency situation; and

b. Submit all life-threatening emergency Hysterectomy cases to the Division for retrospective review.

SUPPLEMENTAL INFORMATION

Coverage of Hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis. Prior to performing a Hysterectomy, providers shall establish medical necessity in part by providing documentation relating to the trial of medical or surgical therapy which has not been effective in treating the Member's condition. The length of such trials shall also be documented in the Member's medical records.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:26 MST)
Anthony Dekker, D.O.

310-M IMMUNIZATIONS

REVISION DATE: 05/10/2023, 10/26/2022
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 32-1974, AMPM 310-V, AMPM 430

PURPOSE

This policy applies to the Division of Developmental Disabilities (The Division) Administrative Services Subcontractors (AdSS). The purpose of this policy is to describe covered immunization services for DDD members who are eligible for ALTCS.

DEFINITIONS

1. "Adult" means an individual 18 years of age and older.
2. "Child" means an individual under the age of 18 years.
3. "Immunization" means the administration of a vaccine to promote the development of immunity or resistance to an infectious disease.
4. "Vaccine" means the preparation administered to stimulate the production of antibodies and provide immunity against one or

several diseases.

POLICY

A. COVERAGE

1. The AdSS shall allow pharmacists and pharmacy interns under the supervision of a pharmacist, within their scope of practice, to administer AHCCCS covered immunizations to adults 19 years and older as specified in A.R.S. § 32-1974.

2. The AdSS shall cover immunizations as appropriate for age, history, and health risk, for adults and children.

3. The AdSS shall follow recommendations as established by the Centers for Disease Control and Prevention (CDC) and theAdvisory Committee on Immunization Practices (ACIP).

4. The AdSS shall not require prior authorization. Prior authorization is not required for medically necessary covered immunizations when administered by an AHCCCS-registered provider.

5. The AdSS shall cover immunizations for adults that include, but are not limited to:
   a. Diphtheria-tetanus,
   b. Influenza,
   c. Coronavirus Disease 2019 (COVID-19),
   d. Pneumococcus,
   e. Rubella,
   f. Measles,
   g. Hepatitis-A,
   h. Hepatitis-B,
   i. Pertussis,
   j. Zoster vaccine, for members 50 and older,
   k. Human Papillomavirus (HPV) vaccine.

6. The AdSS shall cover vaccinations for children as described in AMPM 430.

7. The AdSS shall not cover immunizations for passport or visa clearance, or for travel outside of the United States.

8. The AdSS shall cover pharmacy reimbursement for adult immunizations as described in AMPM 310-V.

Signature of Chief Medical Officer: Anthony Dekker (May 8, 2023 09:53 PDT)
Anthony Dekker, D.O.

310-P MEDICAL EQUIPMENT, MEDICAL DEVICES, AND MEDICAL SUPPLIES

REVISED: 01/01/2021

EFFECTIVE DATE: October 01, 2019

REFERENCES: A.A.C. R9-28-202, A.A.C. R9-22-212, A.A.C. R9-28-101, A.A.C. R9-28-201 42 CFR 440.70, 42 U.S.C. 1396d (a), Division Medical Policy Manual, Policy 430, AdSS Medical Manual Policy Chapter 1020.

Purpose

This policy applies to the Division of Developmental Disabilities (the Division, DDD) Administrative Services Subcontractors (AdSS) that serve DDD Arizona Long Term Care System (ALTCS) members. The Division contracts with AdSS and delegates the responsibility of implementing this policy to those Subcontractors. This policy outlines the requirements for coverage of medically necessary medical equipment, medical devices, appliances, and medical supplies.

Definitions

A. Medical Equipment and Medical Devices - Any item, device, or piece of equipment (as specified in 42 CFR 440.70) is not a prosthetic or orthotic. For this policy's purposes, Medical Equipment, medical devices, and appliances are defined as Durable Medical Equipment (DME) when all the following criteria are met:

1. It is customarily used to serve a medical purpose and is generally not useful to a person in the absence of an illness, disability, or injury.

2. Can withstand repeated use

3. Can be reusable by others or removable.

B. Medical Supplies - Any healthcare-related items that are consumable or disposable or cannot withstand repeated use by more than one member required to address an individual medical disability, illness, or injury.

C. Setting in Which Normal Life Activities Take Place - A setting other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

D. Augmentative and Alternative Communication (AAC) Device Systems - An AAC device systems or speech-generating devices (SGD) represent high-technology aided forms of DME. AAC device systems and SGDs represent forms of external hardware and software systems dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a member with significant communication disorders. AAC device systems produce messages or symbols using one of the following methods:

1. Digitized audible/verbal speech output, using pre-recorded messages.

2. Synthesized audible/verbal speech output, which requires message

formulation by spelling and device access by physical contact with the device-direct selection techniques.

3. Synthesized audible/verbal speech output, which permits multiple methods of message formulation and multiple methods of device access.

4. Software that allows a computer or other electronic device to generate speech.

E. Dedicated AAC Devices - Purpose-built systems primarily designed to serve a medical purpose (e.g., solely for the purpose of expressive communication). Dedicated AAC device systems are generally not useful in the absence of disability, or illness or injury.

F. Integrated AAC Devices - Non-medical systems designed for non-medical purposes and are generally useful in the absence of disability, illness, or injury; however, they may also include functionality for use as a communication tool.

G. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services, and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost-effectiveness, do not apply to EPSDT services.

H. AAC Assessment - A comprehensive AAC assessment includes the culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the member and/or family to the guide decision-making process for AAC methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication. The AAC assessment process may be static (i.e., using procedures designed to describe current levels of functioning within relevant domains) or dynamic (i.e., using hypothesis testing procedures to optimize selection and use of AAC systems).

I. Treatment - Treatment services represent medically necessary skilled interventions conducted at a level of complexity and sophistication that requires the expertise, knowledge, clinical judgment, decision-making of an appropriately credentialed and trained qualified healthcare professional to perform the tasks.

J. Maintenance Plan - A maintenance plan is intended to ensure that the transition of skills achieved within isolated treatment contexts can be maintained across settings after treatment is completed to support the generalization of the achieved communication skills across settings, activities, and communicative partners. A maintenance plan and procedures support the effectiveness of the intervention, the

level of function achieved at the end of the intervention, and the appropriateness of clinical decisions and clinical recommendations. A maintenance plan may result in recommendations for continued or repeated assessment, intervention, and/or referral for other assessments or services.

K. Practitioner - For the purposes of this policy, Practitioner refers to a Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.

Medical Equipment and Medical Devices Coverage

A. The AdSS shall cover medically necessary Medical Equipment, Medical Appliances and Medical Supplies (including incontinence briefs), under the home health services benefit, that are suitable for use in any Setting in Which Normal Life Activities Take Place, as explained in this policy when the following conditions are met:

1. Provided in Settings in Which Normal Life Activities Take Place
2. Ordered by the member's practitioner or beginning March 1, 2020, ordered by the member's:
   - Nurse Practitioner
   - Physician's Assistant
   - Clinical Nurse Specialist
3. As a part of the plan of care and is reviewed by the practitioner annually.
4. Authorized as required by the Division or the AdSS.

B. Medical equipment and medical supplies cannot be limited to members who are homebound.

C. Related Services, AAC Device Systems, and Requirements:

1. Nursing, home health aide, and home health services, as specified in the Division's *Medical Policy 1240-G - Home Nursing, Medical Policy 1240-H - Home Health Aide, and AdSS Medical 310-I – Home Health Services.*
2. Therapies—Occupational, Physical and Speech-Language Pathology (Rehabilitative and Habilitative), as specified in the Division's *AdSS Medical 1250-E Therapies (Rehabilitative and Habilitative*)
3. Orthotic and Prosthetic Devices, as specified in the *AHCCCS Medical Policy Manual (AMPM) 310-JJ - Orthotic and Prosthetic Devices*
4. Prior Authorization Requirements, as specified in the *AMPM 820 - Prior Authorization Requirements*
5. Institutional Services and Settings, as specified in the Division's *AdSS Medical Policy 1210-Institutional Services and Settings*

6. AAC Device Systems, as outlined in this policy.

D. Examples of medically necessary Medical Supplies and Medical Equipment are:

1. Medical Supplies- Incontinence briefs, surgical dressings, splints, casts, and other consumable items are not reusable and explicitly designed to meet a medical purpose.

2. Medical Equipment -Wheelchairs, walkers, hospital beds, AAC device systems, SGDs, AAC software that enables dynamic symbol/language representation used with some form of dedicated hardware, and other durable items that are rented or purchased.

Medical Equipment and Medical Devices Coverage Determinations

A. Medical Equipment and Medical Supply coverage are not restricted to the items covered as DME in the Medicare program. Coverage of Medical Equipment and Medical Supplies cannot be contingent upon the member needing nursing or therapy services.

B. Absolute exclusions for coverage of medical equipment, medical appliance, and medical supplies are prohibited. A list of pre-approved medical equipment, medical appliances, and medical supplies are permissible for administrative ease. However, processes and criteria for requesting medical equipment, appliances, and supplies not on the pre-approved lists shall be made available to members and providers. The procedure shall use reasonable and specific criteria to assess items for coverage.

C. The AdSS shall make determinations of coverage in accordance with all requirements of Exhibit F1 Member Grievance and Appeal System Standards of the AdSS contract and with all requirements of the Division Administrative Service for Subcontractors (AdSS) *Medical Manual Policy Chapter 1020 - Medical Management Scope and Components*. The AdSS shall render the determination within the required timeframes regardless of the member's dual eligibility status or the providers' contract status with the AdSS.

D. To determine coverage of medical equipment and medical supplies, the following shall be used:

1. Services shall be determined to be medically necessary, cost-effective and federally, and state reimbursable.

2. Services shall be provided at the Setting in Which Normal Life Activities Take Place, be on the member's plan of care, and ordered by the member's practitioner.

3. The member's need for medical equipment, appliance, and/or supplies shall be reviewed by a practitioner as specified in this policy, annually. The frequency for further practitioner review for the member's continuing need for services is determined on an individualized, case by case basis based on the nature of the prescribed item.

4. Medical equipment and medical supplies are reasonable and necessary in amount, duration, and scope to achieve the intended purpose.

E. Medical equipment and medical supply coverage determinations are not based solely on the practitioner's prescription. Coverage decisions are based on evidence-based clinical and medical findings, about the member's condition in relation to the medical equipment or medical supplies prescribed. The member's medical record must contain sufficient documentation of the member's medical condition to substantiate the necessity for the prescribed medical equipment or medical supplies. The member's medical record is not limited to the practitioner's office records. It may include hospital, nursing home, or home health agency records and records from other professionals (if applicable) including, but not limited to, nurses, occupational therapists, physical therapists, speech-language pathologists and prosthetists, and orthotics.

F. Services shall be authorized, set up, and maintained to maximize the member's independence and functional level in the most appropriate Setting in Which Normal Life Activities Take Place as defined in this policy.

G. The AdSS shall ensure that the provider network includes a choice of vendors for customized Medical Equipment and Appliances to meet the needs of members.. Timeliness standards for the creation, repair, and delivery of customized Medical Equipment and Appliances shall be in accordance with the AdSS required Utilization, Grievance, and Appeals deliverable and included in the contract with the vendor. The AdSS shall monitor the standards and act when the vendor is found to be out of compliance.

H. Medical equipment may be purchased or rented, and the total expense of the rental cannot exceed the purchase price of the item.

I. Rental fees shall terminate no later than the end of the month in which the member no longer needs the Medical Equipment, or when the member is no longer eligible or enrolled with the AHCCCS, except during transitions as specified by the Division's Chief Medical Officer or designee.

J. Reasonable repairs or adjustments of purchased Medical Equipment are covered when necessary to make the equipment serviceable and when the repair cost is less than the cost of rental or purchase of another unit. In circumstances where the cost of replacement is less than repair, purchase is covered if medically necessary.

Incontinence Briefs

A. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. The AdSS may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered as specified in A.A.C. R9-28-202 to prevent skin breakdown when all the following are met:

1. The member is incontinent due to a documented medical condition that causes incontinence of bowel and bladder.

2. The Primary Care Provider (PCP) or attending practitioner has issued a prescription ordering the incontinence briefs.

3. Incontinence briefs, including pull-ups and incontinence pads, do not exceed 180 in any combination per month unless the prescribing practitioner presents evidence of the medical necessity for more than 180 per month.

4. The member obtains incontinence briefs from vendors within the AdSS network.

5. Prior authorization has been obtained as appropriate. The AdSS must not require a new prior authorization to be issued more frequently than every 12 months.

B. Incontinence Briefs for Members under the Age of 21 Years

1. AdSS shall cover incontinence briefs when necessary to treat a medical condition.

2. AdSS shall cover incontinence briefs for preventative purposes for members over the age of three and under 21 years of age, as described in *Division Medical Policy Manual, Policy 430,* and A.A.C. R9-22-212.

Limitations

A. Except for incontinence briefs as specified in this policy, personal care items, including items for personal cleanliness, body hygiene, and grooming, are not covered unless needed to treat a medical condition.

B. First aid supplies are not covered unless prescribed in accordance with a prescription.

Augmentative and Alternative Communication (AAC) Device Systems

This policy's AAC section provides information and requirements related to medical necessity determination and for coverage of augmentative and alternative communication (AAC), speech-generating device (SGD) systems. The Division bases this policy on generally accepted standards of practice, review of the medical literature, and federal and state policies and laws applicable to the Medicaid program.

The information in this policy is intended for AdSS qualified, licensed, and credentialed healthcare professionals involved in assessing, treating, and supporting Division ALTCS members with significant communication disorders who may benefit from AAC.

Speech-language pathologists' function as the lead professional in the assessment, treatment, monitoring, and management of members with significant communication disorders. Speech-language pathologists support members using AAC in collaboration with multi-professional (multidisciplinary, interdisciplinary, and trans-disciplinary) teams using

family and person-centered, inclusive, and rights-based approaches. The extent of involvement depends on the healthcare professional's expertise, the nature of the clinical setting, the support needs of the member, and the context of the referral.

AAC refers to all communication forms other than oral speech (e.g., pictures, symbols, writing, hand gestures). AAC systems may be unaided (e.g., signing, gestures) or aided. Aided AAC systems include non-technology assistive products (e.g., communication boards, books) and technology-based products (e.g., SGDs, mobile technologies) that compensate for the impairment and disability of a member with a significant communication disorder. AAC systems are used to establish functional communication when natural speech methods are insufficient to achieve daily communication goals and meet communication needs.

Aided AAC systems can be categorized into non-technology and technology-based products. Non-technology products are non-electronic boards or books that contain images that the member selects to convey messages (e.g., picture symbols, alphabet boards, photograph books). Technology-based systems employ hardware and software to produce visual output, that is, digitally displayed messages (i.e., dynamic, or static displays) or voice output (verbal messages [SGDs and mobile AAC software]). For this policy, the term "AAC device system" generally refers to technology-based communication systems with voice output and includes both SGDs AAC software.

Coverage

The provision of AAC systems includes coverage for all AdSS eligible members of all ages if the services, supplies, and accessories are considered medically necessary as defined in A.A.C. R9-28-101 and R9-28-201.

Prior Authorization is required for all AAC Device Systems and services. Refer to *Prior Authorization Requirements* section for requirements. For services to be considered medically necessary, the services must be reasonable and necessary to treat illness, injury, disease, disability, or developmental condition. Medical necessity is a critical factor for determining eligibility for reimbursable therapy and treatment services.

AdSS shall review requests for prior authorization based on medical necessity. If the AdSS approves the request, payment is still subject to all general conditions of the AdSS, including member eligibility, other insurance, and program restrictions.

Benefits

A. Items that are included in the AdSS covered benefits for an AAC device system and are not reimbursed separately include, but are not limited to, the following:

   1. Applicable software (except for software purchased specifically to enable a member-owned computer or a Personal Digital Assistant (PDA) to function as an AAC device system).

   2. Batteries

   3. Battery charger

   4. Power supplies

5. Interface cables

6. Interconnects

7. Sensors

8. Alternating Current (A/C) or other electrical adapters

9. Adequate memory to allow for system expansion within a 3-year time frame

10. Access device when necessary

11. Mounting device when necessary

12. Any extended warranty

13. Carrying case

14. Any medically necessary treatment services for the programming and modification or adaptation of purchased devices by the Division, the AdSS, or the primary payor.

B. Other Benefit Considerations

Replacement of applications covers the following:

1. If the application was deleted.

2. Cannot be accessed due to loss of username and password.

C. Limitations

Non-covered items that are not necessary to operate the device and are unrelated to the AAC system or software components are not covered. These items include, but are not limited to:

1. Printer

2. Wireless Internet access devices.

Medical Review Criteria

The AdSS must review the assessment and clinical documentation to determine medical necessity. The AdSS shall base its determination of the medical necessity for the coverage of AAC device hardware, software, and skilled treatment services for systems dedicated to transmitting or producing messages or symbols, based on the evidence-based clinical and medical records including, but not limited to, indicators that would affect the relative risks and medical benefits of the AAC device system, and the following criteria:

A. The member has a significant communication disorder related to a medical condition or developmental disability that significantly limits daily functional communication.

B. The member cannot meet daily functional communication needs by using unaided forms (natural modes) of communication.

C. The member has had a formal, face-to-face comprehensive speech-language assessment administered according to the generally accepted standards of practice by an appropriately credentialed and trained speech-language pathologist within one calendar year before the date of the written prior authorization request. Refer to the Division's *Medical Policy Manual*; *Policy 1250-E Therapies (Rehabilitative/Habilitative) for Therapy* assessment requirements. Refer to the American Speech-Language-Hearing Association (ASHA) Preferred Practice Patterns for the Profession of Speech-Language Pathology for "*The Fundamental Components and Guiding Principles for Comprehensive Speech-Language Assessment.*"

D. A formal AAC assessment has been conducted by an appropriately credentialed and trained speech-language pathologist to determine and recommend methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication in accordance with the " *Assessment Requirements"* section of this policy. Refer to the ASHA Preferred Practice Patterns for the Profession of Speech-Language Pathology for "*The Fundamental Components and Guiding Principles for AAC Assessment."*

E. The recommended AAC device system is the least costly and clinically appropriate.

F. The recommended AAC device system matches the cognitive, visual, language, and physical abilities of the member.

G. The viability for use, including the member's physical and behavioral health care needs, is considered for the type of AAC device system recommended. The member has demonstrated the ability to learn to use the recommended AAC device system and accessories or software for functional communication as evidenced by a data-driven AAC device system trial supporting the ability to use the AAC device system and any necessary accessories functionally for communication. Refer to Prior Authorization Requirements of this policy for device trial requirements. For a subsequent upgrade of a previously provided AAC device system or software, evidence-based clinical and medical findings including, but not limited to, indicators that would affect the relative risks and medical benefits of the AAC device system should demonstrate why the initially covered AAC device system or software is no longer clinically effective in meeting the member's medical need.

H. When the medical necessity for an AAC device system is established, coverage may include dedicated devices and—under certain circumstances, for members under 21 years old—integrated devices systems. The medical necessity for an AAC device must be met regardless of whether the member's provider recommends a dedicated or integrated AAC device system, and the AAC device system must be functional for use in all environments, including in school, in the home and in community settings.

I. Clinical documentation includes applicable descriptions that align with the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* diagnosis codes. Diagnosis descriptions must be to the highest level of specificity available. Diagnosis codes that are included must be appropriate for the

age of the member, as identified in the ICD-10-CM description of the diagnosis code.

Refer to the Official ICD-10-CM and American Speech-Language-Hearing Association (ASHA) resources for the most up-to-date information on ICD coding:

- *National Center for Health Statistics: www.cdc.gov/nchs/icd/icd10.htm*
- *Centers for Medicare and Medicaid Services: www.cms.gov/ICD10/*
- *ICD-10-CM Official Guidelines for Coding and Reporting: www.cdc.gov/nchs/icd/data/10cmguidelines-FY2020_final.pd*
- *ICD-10-CM Diagnosis Codes for Audiology and Speech-Language Pathology: www.asha.org/Practice/reimbursement/coding/ICD-10/*
- *ICD-10-CM Coding FAQs for Audiologists and SLPs: www.asha.org/Practice/reimbursement/coding/ICD-10-CM-Coding-FAQs-for-Audiologists-andSLPs/*
- *Coding Normal Results: www.asha.org/practice/reimbursement/coding/normalresults/*
- *Coding to the Highest Degree of Specificity: www.asha.org/practice/reimbursement/coding/codespecificity/*

Note: Refer to the Division's Health Plan Guide to Augmentative and Alternative Communication (AAC) Systems for further coding information.

EPSDT Criteria

Service limitations and exclusions for AAC systems, other than the requirement for medical necessity and cost-effectiveness, do not apply to members under the age of 21.

Service limitations on scope, amount, duration, frequency, or other specific criteria described in this policy may be exceeded or may not apply to members under the age of 21. Clinical documentation must include how the service, product, or procedure will correct or ameliorate defects, or improve or maintain the member's health, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Refer to the Division's Health Plan Guide to *Augmentative and Alternative Communication (AAC) Systems* for EPSDT information.

Prior Authorization Requirements

Prior authorization is required for AAC systems and services provided through the AdSS. The prior authorization also includes all related accessories and supplies.

All relevant clinical and medical documentation, including the member's medical records, Practitioner's office records, therapy service records, other records from healthcare professionals, and test reports as requested by the AdSS relevant to the request should be

submitted or may be requested to support/demonstrate that the coverage criteria for an AAC device system is medically necessary and that other requirements have been met.

The AdSS shall comply with all prior authorization requirements, including timeliness standards in accordance with Exhibit F1 Member Grievance and Appeal System Standards of the AdSS contract.

If during the prior authorization review additional information is requested or the device does not meet clinical criteria, the AdSS is required to offer a peer to peer discussion and shall coordinate the discussion with the requesting provider when appropriate and comply with the Division's *Administrative Service for Subcontractors (AdSS) Medical Manual Policy Chapter 1020 - Medical Management Scope and Components.*

- Prior authorization is required for:
  - AAC device system rentals or purchases
  - AAC device system modifications
  - All AAC device system accessories
  - Replacement of AAC device system or components
  - AAC device system repairs
  - Treatment services for the programming and modification or adaptation of an AAC device system.
- Prior authorization may not be required for device trial, initial device mounting, and initial treatment units.

A. AAC Device System Purchases or Rentals

1. Prior authorization requests for AAC device system purchases must consider all projected changes in the member's communication abilities for a minimum of three years. AAC device systems that have been purchased are anticipated to last a minimum of three years.

2. An AAC device system is not approved for purchase unless the member has used the requested AAC device system for a trial period a minimum of three devices are required to be trialed.

3. Prior authorization is required for AdSS rental or loaner coverage for the trial period, as requested. All components, accessories, and switches, including mounting devices and lap trays necessary for use, may be used during the trial period before a decision to purchase can be approved. If an AAC device system is unavailable for rental, a waiver of the trial period may be granted by the AdSS with supporting documentation.

4. Prior authorization requests must include all the following information or documentation:

a. Include a detailed written order or prescription for the purchase or rental of the prescribed AAC device system by the member's practitioner. The detailed written order must:

- Be signed and dated by the licensed practitioner, familiar with the member dated within 365 days of the prior authorization request.
- Include the National Provider Identifier (NPI) numbers of the prescribing qualified health professional.
- Include an itemized description, including quantities, manufacturer's name, model, and retail price for all prescribed AAC device system accessories, components, mounting devices, modifications for the member to use the AAC device system.

b. Include a plan of care established by an appropriately credentialed and trained speech-language pathologist and prescribed by the member's practitioner for the treatment services to use the AAC device system. The plan of care must:

- Be signed and dated by the member's evaluating or treating licensed and certified speech-language pathologist.
- Include the NPI numbers of all the qualified health professionals certifying the plan of care.
- Include an itemization of the anticipated treatment service dosage (amount, frequency, and duration) necessary for the member to use the AAC device system, not to exceed a service period more than 365-days without revision and review.
- Include the Current Procedural Terminology (CPT) for the treatment services that most appropriately represent the proposed procedures or services established.
- Include the long-term and short-term goals of the treatment services based on the generally accepted standards of practice represented as functional, measurable, and time-specific objectives.
- Include the maintenance plans for discharge from treatment.
- Include a description of the member's progress, as applicable, toward the established goals, the home-programing provided, collaboration with other professionals and services, any appropriate modifications to the initial plan of care, and plans for continuing care.

c. Documentation of the appropriate ICD-10-CM medical and treating diagnoses (if applicable) and a description of how the diagnoses relate

to the member's communication needs and any significant medical information pertinent to the use of the AAC device system.

d. The written report of the member's current communication abilities and levels of function, including the results as reported on the member's most recent formal, face-to-face comprehensive speech-language assessment administered according to the generally accepted standards of practice by an appropriately credentialed and trained speech-language pathologist, within one calendar year before the date of the written prior authorization request.

Refer *to* the *Division's Medical Policy Manual; Policy 1250-E Therapies (Rehabilitative/Habilitative)*

e. Documentation to demonstrate how the prescribed AAC device system is medically necessary and the most effective form of communication to correct or improve or maintain the member's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems, with a comparison of benefits versus alternative communication forms.

f. The written AAC assessment report is conducted by a speech-language pathologist individually, or in collaboration with the multidisciplinary, which may include the member being assessed, family/caregivers, and other relevant professionals (e.g., educational, vocational, and medical personnel).

g. The current Individual Support Plan/Individualized Family Services Plan/Person-Centered Plan (Planning Documents), including long-term communication goals.

B. AAC Device System Repairs

All repairs require prior authorization. Non-Warranty repairs of an AAC device system require documentation from the manufacturer explaining why the repair is not covered by warranty and medical necessity documentation. During the repair process period, a short-term rental of a device may be allowed.

The following prior authorization documentation for AAC device system repairs is required:

1. A prescription from the treating Practitioner

2. A statement that describes the needed repair

3. Justification of medical necessity

4. The estimated cost of repairs is determined by the DME supplier.

C. AAC Device System Replacement

Replacement of AAC device system or components require prior authorization and is considered in the following circumstances:

1. When loss or irreparable damage has occurred

2. It has been three (3) years since the initial prescription, and the AAC device system is no longer functional.

3. Documentation supports medical necessity or appropriateness of replacing the current AAC device system.

4. The following prior authorization documentation for AAC device system replacement is required:

   A joint statement from the prescribing practitioner's and a licensed speech-language pathologist that includes:

   a. The cause of loss or damage and what measures have been taken to prevent recurrences.

   b. Information stating the member's abilities or communication needs are unchanged if the device replacement is greater than three years of initial device order, or no other AAC device systems currently available are better suited to the member's needs.

   c. A new evaluation if requesting a different AAC device system from one that has been lost or damaged.

D. AAC Device System Treatment

1. The authorization and provision of AAC device system treatment and intervention includes four-unit of initial treatment services for the member in the appropriate use of the AAC device system by the speech-language pathologist.

2. The treating speech-language pathologist is responsible to coordinate, schedule, and confirm the services for the member. The initial services must include the following interventions:

   a. Treatment services for the use of AAC device system

   b. Programming and modification

   c. Established on the member's plan of care by a qualified speech-language pathologist.

3. The intervention must include, but not be limited to:

   a. The provision of appropriate information related to set up, features, routine use, troubleshooting, cleaning, infection control practices, and

other issues related to the use and maintenance of all devices and accessories provided.

i. Treatment and instruction materials tailored to the needs, abilities, learning preferences, and language of the member and appropriate.

ii. Confirmation that the member can use all devices and accessories provided safely and effectively in the settings of anticipated use.

iii. Written description of the instruction and the provision of such instruction in the member's clinical treatment and progress report record to include, but not be limited to:

- Instructions commensurate with the risks, complexity, and manufacturer's instructions and specifications for the device.
- Instruction provided to the member, or the member's caregiver, in the appropriate use of the AAC device system provided to the member.

Assessment Requirements

A. AAC assessment is provided to determine and recommend methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication. These components, in any combination, are known collectively as an AAC system.

B. AAC assessments are conducted by appropriately credentialed and trained speech-language pathologists. AAC evaluations shall be completed and submitted to AdSS within 65 days of the initiating referral, including the device trial period of up to 30 days.

C. Speech-language pathologists may perform these assessments individually or as members of collaborative teams that may include the individual being assessed, family/caregivers, and other relevant persons (e.g., educational, vocational, and medical personnel).

D. AAC assessment is conducted to identify, measure, and describe these expected outcomes:

1. Structural/functional strengths and deficits related to speech and language factors that affect communication performance and justify the need for AAC devices, equipment, materials, strategies, and/or services to augment speech production or comprehension, to support and promote spoken and written language learning, or to provide an alternative mode of communication.

2. Effects of speech-language and communication impairments on the individual's activities and participation (capacity and performance in everyday

communication contexts), and how an AAC system would support such activities and participation.

3. Contextual factors that serve as barriers to or facilitators of successful communication and participation for individuals who need AAC systems.

4. Assistance to members in selecting and obtaining components (e.g., aids, techniques, symbols, strategies) to optimize communication and activity/participation.

5. Recommendations for AAC systems, for AAC intervention, for follow-up, and for a referral for other examinations or services.

E. Clinical Indications:

1. AAC assessment services are provided to members as needed, as requested, or mandated or when other evidence suggests that individuals have communication impairments associated with their body structure/function and/or activities/participation that might justify the need for an AAC system.

2. An assessment is prompted by referral, by the individual's speech-language, communication, educational, vocational, social, and/or health needs, or following completion of a speech-language assessment that is sensitive to cultural and linguistic diversity.

F. Clinical Assessment:

A comprehensive assessment is sensitive to cultural and linguistic diversity. The assessment may be static (i.e., using procedures designed to describe current levels of functioning within relevant domains) or dynamic (i.e., using hypothesis testing procedures to optimize selection and use of AAC systems), and includes the following:

1. Review of auditory, visual, neuromotor, speech-language, and cognitive status, including observation of posture, gross and fine motor coordination, and any existing adaptive and/or orthotic devices currently used by the patient/client (e.g., wheelchair, neck braces, communication devices and/or techniques, other specialized equipment).

2. Relevant case history information, including medical status, education, vocation, socioeconomic, cultural, and linguistic background regarding activities in which the person needs an AAC system to support communication.

3. Standardized and/or non-standardized methods for assessing the individual's use and acceptance of a range of AAC devices, aids, symbol systems, techniques, and strategies.

4. Examination of specific aspects of voice, speech, language (e.g., spoken, written language samples, and reading level), cognition, and existing communication options and abilities.

5. Methods for identifying associated barriers and facilitators that are addressed in an intervention plan.

6. Varied parameters of the AAC assessment(e.g., tests, materials) that depend on levels of severity, whether the patient/client is a child or an adult, and whether the expressive or receptive communication disorder is congenital or acquired.

7. Selection of measures for AAC assessment with consideration for ecological validity, environments in which AAC systems routinely will be used, technology and device features, and preferences of the patient/client and communication partners (e.g., family/caregivers, educators, service providers).

8. The assessment of a range of potential AAC systems in multiple controlled and natural contexts.

9. Follow-up services to monitor individuals with identified speech-language and communication disorders justifying the need for AAC systems.

10. Cognitive-communication and language status

11. Appropriate intervention and support

12. Optimal use of the recommended AAC system

13. Adjustments in the AAC system as necessary

14. Assessment of the member's ability to use the AAC system effectively in various contexts, with adjustments made to the system, as necessary.

G. Assessment Report:

A written AAC assessment report by a licensed speech-language pathologist is required with the request for prior authorization and may include the following information:

1. Communication status and limitations, including prognosis for speech or written communication and documentation of previous use of low technology devices such as picture boards. Sensory functioning

   a. Hearing ability

   b. Visual abilities

   c. Postural abilities

   d. Physical status

2. A description of the member's cognitive readiness

3. Behavioral and learning abilities observed, evaluated, or gathered from

records of assessments:

a. Executive function skills, including:

i. Attention span

ii. Memory

iii. Problem-solving skills

iv. Ability to understand cause and effect.

v. Presence of significant behaviors, such as physical aggression and property destruction.

b. Motor abilities and assessments, if applicable:

Gross motor abilities (e.g., ambulatory, or walks with crutches/walker, or uses a wheelchair; seating and positioning/posture; head control and trunk mobility; ability to use a head stick).

c. Fine motor and upper-extremity abilities and function (e.g., ability to point, type, write, access a device via direct selection).

d. Ability to access via gaze, head mouse, single-switch or multiple-switch scanning, or other alternative access methods.

e. Treatment options considered, including types of communication support used in the past to meet goals, and why each is or is not appropriate.

4. The results of the data driven AAC device or software trials, including the following information for each device or software trialed:

a. Length of trial

b. Data collected during the trial

c. The environment in which the AAC device system and/or software trial took place (e.g., home, school, community).

d. The manner in which the device or software was accessed (e.g., gaze, direct selection, scanning).

e. Member's ability to learn to use the device or software functionally for communication.

f. A sampling of messages communicated, including frequency, level of cueing, and communication partner(s).

g. Number of messages expressed in a time period and level of cueing required for expression of such messages.

h. The degree to which the member was able to move beyond the exploratory phase and use the device or software to communicate intentionally, whether such progress occurred in both structured and unstructured settings, and with what level of proficiency progress beyond the exploratory phase occurred.

5. Description of the recommended device/accessory/software, the rationale for selection (including cost comparisons among the devices or software trialed), and how the recommended option meets the communication needs of the member.

Durable Medical Equipment Service Delivery Reporting

The AdSS shall provide reporting for timeliness of DME service delivery for specified DME as required in the Medical Equipment Service Delivery deliverable in accordance with the AdSS contract.

310-R NURSING FACILITY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division of Developmental Disabilities (Division) covers medically necessary services rehabilitative services provided in Nursing Facilities (NF) for members who are eligible for Arizona Long Term Care System (ALTCS) with acute medical needs and who need nursing care 24 hours a day but who do not require hospital care under the daily direction of a physician. NF service providers must be state licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements. Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

See Chapter 1210 of this manual regarding Institutional Services for members who are ALTCS eligible.

The Division covers services for members who have acute medical needs and are eligible for ALTCS. The following requirements apply:

A. The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting (i.e., home with home health services).While convalescent care should be considered short-term, the Contractor shall extend NF coverage as medically necessary. The AdSS must contact the Division by Day 45 of the member's placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in Chapter 1210 of this manual, the AdSS must obtain approval from the Division.

B. For members enrolled in the ALTCS Transitional Program whose health status indicates that the member will likely require NF placement for longer than 90 days, the AdSS shall provide notification to the Division's assigned Support Coordinator. The Support Coordinator shall notify AHCCCS for consideration of continued enrollment in the Transitional Program or a change to ALTCS status.

Services that are not covered <u>separately</u> when provided in an NF include:

A. Nursing services, including:

1. Administration of medication
2. Tube feedings
3. Personal care services
4. Routine testing of vital signs and blood glucose monitoring
5. Assistance with eating
6. Maintenance of catheters.

B. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

C. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

D. Administrative physician visits made solely for meeting state certification requirements

E. Non-customized durable equipment and supplies such as manual wheelchairs, geriatric chairs, and bedside commodes

F. Rehabilitation therapies ordered as a maintenance regimen

G. Administration, Medical Director Services, plant operations, and capital

H. Over-the-counter medications and laxatives

I. Social activity, recreational and spiritual services

J. Any other services, supplies or equipment that are state or county regulatory requirements or are included in the NF's room and board charge.

310-V PRESCRIPTION MEDICATION PHARMACY SERVICES

REVISION DATE: 1/24/2024, 1/10/2024, 09/21/2022, 6/22/2022, 3/1/2022, 10/1/2021, 9/30/2020
REVIEW DATE: 9/21/2022
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.52; 42 CFR 438.3(s); 42 USC 1396A(OO); A.R.S. § 32-1974; A.R.S. § 32-3248.01; A.R.S. § 36-550; A.R.S. §36-551; A.R.S. § 36-2918(A)(1); A.R.S. §36-2918(A)(3)(b); A.R.S. § 36-2930.03; A.A.C. 4-23-402; A.A.C. R4-23-409; R9-22-201 et seq; A.A.C. R9-22-209(C); A.A.C. R9-22-702; A.A.C. R9-22-709; A.A.C. R9-22-710(C); A.A.C. R9-22-711; A.A.C. R9-28-201 et seq; A.A.C. R9-31-201 through R9-31-216; A.A.C. § 9-22-203; Social Security Act Section 1927 (g) Drug Use Review; AMPM 310-DD, AMPM 310-M, AMPM 320-N, AMPM 320-Q; AMPM 320 T-1; AMPM 320 T-2; AMPM 660; AMPM Attachment 310-V (A); AMPM Attachment 310-V (B); AMPM Attachment 310-V (C); AMPM Exhibit 300-1; AMPM 510; AHCCCS Fee For Service Billing Manual Chapter 12; ACOM 111; ACOM 201; ACOM 414 ACOM 432.

PURPOSE

This policy specifies the medication, device, and pharmacy coverage requirements and limitations of the Arizona Health Care Cost Containment System (AHCCCS) pharmacy benefit for Division of Developmental Disabilities (Division) Members enrolled in health plans managed by Administrative Services Subcontractors (AdSS) and for Members enrolled in the Tribal Health Program administered by AHCCCS Division of Fee-For-Service Management (DFSM) and it’s contracted Pharmacy Benefits

Manager (PBM).

DEFINITIONS

1. "340B Ceiling Price" means the maximum price that drug manufacturers may charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to the United States Department of Health and Human Services. The 340B Ceiling Price per unit is defined as the Average Manufacturer Price (AMP) minus the Federal Unit Rebate Amount.

2. "340B Contracted Pharmacies" means a separate pharmacy that a 340B Covered Entity contracts with to provide and dispense prescription and physician-administered drugs using medications that are subject to 340B Drug Pricing Program.

3. "340B Covered Entity" means an organization as defined by 42 United States Code Section 256b that participates in the 340B Drug Pricing Program.

4. "340B Drug Pricing Program" means the discount drug

purchasing program described in Section 256b of 42 United States Code.

5. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AdSS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program.

6. "Actual Acquisition Cost" or "AAC" means the purchase price of a drug paid by a pharmacy net of all discounts, rebates, chargebacks, and other adjustments to the price of the drug, not including Professional Fees.

7. "Adverse Drug Event" or "ADE" means an injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to Medication Errors, adverse drug

reactions, allergic reactions, and overdose.

8. "AHCCCS Division of Fee-For-Service Management" or "DFSM" means the division responsible for the clinical, administrative and claims functions of the THP members.

9. "AHCCCS Drug List" means a list of Preferred Drugs in specific therapeutic categories that are Federally and State reimbursable behavioral health and physical health care medications and Medical Devices that the AdSS utilize for the administration of acute and long-term care pharmacy benefits. The AHCCCS Drug List includes Preferred Drugs and was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications and is supported by current evidence-based medicine.

10. "AHCCCS Fee For Service (FFS) PA criteria effective 10/1/22" means criteria which is based on clinical appropriateness, scientific evidence, and any of the following standards of practice:

    a. FDA approved indications and limits;

b. Published practice guidelines and treatment protocols;

c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential Member outcomes;

d. Drug Facts and Comparisons;

e. American Hospital Formulary Service Drug Information;

f. United States Pharmacopeia – Drug Information;

g. DRUGDEX Information System;

h. UpToDate;

i. MicroMedex;

j. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies; or

k. Other drug reference resources.

11. "AHCCCS Pharmacy and Therapeutics Committee" or "AHCCCS P&T Committee" means the advisory committee to AHCCCS, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List. The AHCCCS Pharmacy and Therapeutics Committee (AHCCCS P&T Committee) is primarily composed of physicians, pharmacists, nurses, other health care professionals and community members.

12. "Average Manufacturer Price" or "AMP" means the average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts.

13. "Biosimilar" means a biological drug approved by the Food and Drug Administration (FDA) based on a showing that it is highly similar to an FDA-Approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

14. "Centers For Medicare and Medicaid Services" or CMS" means the Federal agency within the United States Department of

Health and Human Services (HHS) that administers the Medicare program and works in partnership with State governments to administer Medicaid.

15. "Chronic Intractable Pain" means as specified in A.R.S. § 32-3248.01, meets both of the following:
    a. The pain is excruciating, constant, incurable and of such severity that it dominates virtually every conscious moment; and
    b. The pain produces mental and physical debilitation.
16. "Dual Eligible Member" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members:
    a. A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only); or
    b. A Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

17. "Emergency Medication" means for the purposes of this policy, emergency epinephrine and diphenhydramine.

18. "Federal Supply Schedule" or "FSS" means the collection of multiple award contracts used by Federal agencies, U.S. territories, Indian tribes, and other specified entities to purchase supplies and services from outside vendors. Federal Supply Schedule (FSS) prices for the pharmaceutical schedule are negotiated by the Veterans Affairs and are based on the prices that manufacturers charge their "most-favored" non-Federal customers under comparable terms and conditions.

19. "Federal Unit Rebate Amount" means a calculation using the drug manufacturer's pricing. The specific methodology used is determined by statute, and depends upon whether a drug is classified as:

    a. Single source ("S" drug category) or Innovator multiple source ("I" drug category);

    b. "S" or "I" Line Extension Drug;

c. Non-innovator multiple source ("N" drug category);

d. Clotting Factor drug (CF); or

e. Exclusively Pediatric drug (EP).

20. "First Line Drug" a generic drug or lower-cost drug.

21. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes Fraud under applicable State or Federal law.

22. "Generic Drug" means a drug that contains the same active ingredients as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic Drug substitution shall be completed in accordance with Arizona State Board of Pharmacy rules and regulations.

23. "Grandfathering of Non-Preferred Drugs" means the continued

authorization of Non-Preferred Drugs for Members who are currently utilizing Non-Preferred Drugs without having completed Step Therapy of the Preferred Drugs on the AHCCCS Drug List, as appropriate.

24. "Guest Dosing" means A mechanism for Members who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for Members who need to travel for a period of time that exceeds the amount of eligible take-home doses.

25. "Initial Prescriptions for Short-Acting Opioid Medication" means a written or electronic order for a short-acting opioid medication that the Member has not previously filled any prescription for within 60 days of the date of the pharmacy filling the current prescription as evidenced by the Member's PBM prescription profile.

26. "JW Modifier" means a Healthcare Common Procedure Coding System (HCPCS) Level II modifier required to be reported on a

claim to report the amount of drug that is discarded and eligible for payment under the discarded drug policy.

27. "Medical Device" means per Section 201(h) of the Food, Drug, and Cosmetic Act, a device is: An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, other similar related article, including a component part, or accessory which is:

    a. Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them;

    b. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease, in man or other animals;

    c. Intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals; and

    d. Which does not achieve its primary intended purposes

through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. The term "device" does not include software functions excluded pursuant to Section 520(o) of the Federal Food, Drug and Cosmetic Act.

28. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

29. "Naloxone" means a prescription medication that reverses the effects of an opioid overdose.

30. "Nominal Price" means a drug that is purchased for a price that is less than 10% of the AMP in the same quarter for which the AMP is computed.

31. "Non-Preferred Drug" means a medication that is not listed on the AHCCCS Drug List. Non-Preferred Drugs require Prior Authorization (PA).

32. "Non-Title XIX/XXI Member" means a Member who needs or may

be at risk of needing covered health-related services but does not meet Federal and State requirements for Title XIX or Title XXI eligibility.

33. "Preferred Drug" means a medication that has been clinically reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List as a Preferred Drug due to its proven clinical efficacy and cost effectiveness.

34. "Professional Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Professional Fee does not include any payment for the drug being dispensed.

35. "Repack" or "Repackage" means the act of taking a finished drug product or unfinished drug from the container in which it was placed in commercial distribution and placing it into a different container without manipulating, changing, or affecting the composition or formulation of the drug.

36. "Responsible Person" means the parent or guardian of a minor

with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

37. "Standing Order" means an AHCCCS registered prescriber's order that can be exercised by other health care workers for a Member that meets the designated criteria by the prescribing provider.

38. "Step Therapy" means the practice of initiating drug therapy for a medical condition with the most cost-effective and safe drug and stepping up through a sequence of alternative drug therapies if the preceding treatment option fails.

39. "Usual and Customary Price" or "U&C Price" means the dollar amount of a pharmacy's charge for a prescription to the general public, a special population, or an inclusive category of customers that reflects all advertised savings, discounts, special promotions, or other programs including membership-based

discounts.

40. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. THE AHCCCS DRUG LIST

1. The AdSS shall maintain its own drug list to meet the unique needs of the Members they serve. The AdSS drug list shall include all the drugs listed on the AHCCCS Drug List.

2. The AdSS shall cover all medically necessary, clinically appropriate, and cost-effective medications that are Federally and State reimbursable regardless of whether these medications are included on the AHCCCS Drug List.

3. The AdSS shall maintain Preferred Drug lists that include every drug exactly as listed on the AHCCCS Drug List.

4. The AdSS shall not add other Preferred Drugs to their Preferred

Drug lists in those therapeutic classes when the AHCCCS Drug List specifies a Preferred Drug in a particular therapeutic class.

5. The AdSS shall inform their Pharmacy Benefit Managers (PBM) of the Preferred Drugs and shall require the PBM to institute Point-of-Sale (POS) edits that communicate back to the pharmacy the Preferred Drugs of a therapeutic class whenever a claim is submitted for a Non-Preferred Drug.

6. The AdSS shall cover Preferred Drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS with an effective date by the first day of the first month of the quarter following the AHCCCS P&T Committee meeting, unless otherwise communicated by AHCCCS.

7. The AdSS shall approve the Preferred Drugs listed for the therapeutic classes contained on the AHCCCS Drug List, as appropriate, before approving a Non-Preferred Drug unless:
   a. The Member has previously completed Step Therapy using the Preferred Drugs; or

b. The Member's prescribing clinician provides documentation supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the Member.

8. The AdSS shall not disadvantage one Preferred Drug over another Preferred Drug when AHCCCS has approved Preferred Drugs or supplemental rebates for a therapeutic class.

9. The AdSS shall not require Prior Authorization (PA) criteria to require a trial and failure of one preferred agent when there are others that are also preferred and have the same indication.

10. The AdSS shall require PA for the Non-Preferred Drug when the prescribing clinician is not in agreement with transition to the Preferred Drug.

11. The AdSS shall not provide a Notice of Adverse Benefit Determination when the prescribing clinician agrees with the change to the First Line or Preferred Drug.

12. The AdSS shall issue a Notice of Adverse Benefit Determination for service authorizations when a PA request for a Preferred Drug

is denied or a previously approved authorization is terminated, suspended, or reduced.

13. The AdSS shall Grandfather Members on medications that AHCCCS has communicated to the Division and AdSS as approved for Grandfathering.

14. The AdSS shall ensure all Federally and State reimbursable drugs that are not listed on the AHCCCS Drug List or the AdSS drug lists are available through the PA process.

15. The AdSS shall not deny a Federally and State reimbursable medication solely due to the lack of an FDA indication. Off-Label prescribing may be clinically appropriate when evidenced by subsections (a) through (k) above.

16. The AdSS shall be prohibited from adding PA or Step Therapy requirements to medications listed on the AHCCCS Drug List when the List does not specify these requirements.

17. The AdSS shall be prohibited from denying coverage of a medically necessary medication when the Member’s primary

insurer, other than Medicare Part D, refuses to approve the request and the primary insurer's grievance and appeals process has been completed.

18. The AdSS shall evaluate the medical necessity of the submitted PA for all Federally and State reimbursable medications, including those listed and those not listed on the AHCCCS Drug List.

19. The AdSS shall evaluate the submitted PA request on an individual basis for medications that are Non-Preferred Drugs and not listed on the AHCCCS Drug List.

20. The AdSS shall submit requests for medication additions, deletions, or other changes to the AHCCCS Drug List to the AHCCCS P&T Committee for review no later than 60 days prior to the AHCCCS P&T Committee meeting to the AHCCCS Pharmacy Department email at: AHCCCSPharmacyDept@azahcccs.gov.

21. The AdSS shall provide the following information with the request for medication additions, deletions, or other changes to

the AHCCCS Drug List:

a. Name of medication requested (brand name and generic name);

b. Dosage forms, strengths, and corresponding costs of the medication requested;

c. Average daily dosage;

d. FDA indication and accepted off-label use;

e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List;

f. Adverse Drug Event (ADE) reported with the medication;

g. Specific monitoring requirements and costs associated with these requirements; and

h. A clinical summary for the addition, deletion, or change request.

22. The AdSS shall adopt the quantity limits and Step Therapy requirements exactly as they are presented on the AHCCCS Drug

List for all Preferred Drugs specified on the AHCCCS Drug List.

23. The AdSS shall develop Step Therapy requirements for therapeutic classes when there are no Preferred Drugs identified on the AHCCCS Drug List.

24. The AdSS shall obtain PA for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug.

25. The AdSS shall issue a Notice of Adverse Benefit Determination for service authorizations when a PA request for quantity limits or Step Therapy is denied, or a previously approved authorization is terminated, suspended, or reduced.

B. GENERIC AND BIOSIMILAR DRUG SUBSTITUTIONS

1. The AdSS shall utilize a mandatory Generic Drug substitution policy that requires the use of a generic equivalent drug whenever one is available, except for the following:
   a. A brand name drug shall be covered when a generic

equivalent is available and the AHCCCS negotiated rate for the brand name drug is equal to or less than the cost of the Generic Drug; or

b. When the cost of the Generic Drug has an overall negative financial impact to the State. The overall financial impact to the State includes consideration of the Federal and supplemental rebates.

2. The AdSS shall require prescribing clinicians to clinically justify the use of a brand-name drug over the use of its generic equivalent through the PA process.

3. The AdSS shall not transition to a Biosimilar drug until AHCCCS has determined that the Biosimilar drug is overall more cost-effective to the State than the continued use of the brand name drug.

4. The AdSS shall provide the Division with the Generic Drug substitution policy during the Operational Review.

C. ADDITIONAL INFORMATION FOR MEDICATION COVERAGE

1. The AdSS shall cover medications for Members transitioning to a different health plan or FFS as follows:
    a. The transferring AdSS or AHCCCS DFSM provide coverage for medically necessary, cost-effective, and Federally and State reimbursable medications until such time that the Member transitions to their new health plan or FFS Program; and
    b. The AdSS, providers, and Tribal Regional Behavioral Health Authorities (TRBHAs) are responsible for coordinating care when transferring a Member to a new health plan or FFS Program to ensure that the Member's medications are continued during the transition.
2. The AdSS shall provide coverage for medically necessary, cost-effective, and Federally and State reimbursable behavioral health medications provided by a Primary Care Physician (PCP) within their scope of practice which includes the monitoring and adjustments of behavioral health medications.

3. The AdSS shall obtain PA for antipsychotic medication class based on age limits depending on the form of the medication.

4. The AdSS shall ensure PCPs and BHMPs coordinate the Member's care and that the Member has a sufficient supply of medications to last through the date of the Member's first appointment with the PCP or BHMP when a Member is transitioning from a BHMP to a PCP or from a PCP to a BHMP.

5. The AdSS shall allow an individual receiving Methadone or Buprenorphine administration services who is not a recipient of take-home medication to receive Guest Dosing of Methadone or Bupenorphine from the area contractor when the individual is traveling outside of home Opioid Treatment Program (OTP) center.

6. The AdSS shall allow a Member to be administered sufficient daily dosing from an OTP center other than their home OTP center when:

   a. A Member is unable to travel to the home OTP center, or

b. When traveling outside of the home OTP center's area.

7. The AdSS shall allow a Member to receive Guest Dosing from another OTP center (guest OTP center) within their Geographic Service Areas (GSA), or outside their GSA.

8. The AdSS shall approve Guest Dosing outside the State of Arizona when the prescribing physician determines the Member's health would be endangered if travel were required back to the state of residence.

9. The AdSS shall permit a Member to qualify for Guest Dosing when:

   a. The Member is receiving administration of Medications for Opioid Use Disorder (MOUD) services from a SAMHSA-Certified OTP (Substance Abuse and Mental Health Services Administration);

   b. The Member needs to travel outside their home OTP center area,

c. The Member is not eligible for take home medication, and

d. The home OTP center (sending OTP center) and guest OTP center have agreed to transition the Member to the guest OTP center for a scheduled period of time.

10. The AdSS shall not charge Title XIX/XXI Members for Guest Dosing except as permitted by A.A.C. R9-22-702 and A.A.C. R9-22-711.

11. The AdSS shall not charge Non-Title XIX/XXI eligible Members copayments for Guest Dosing.

D. OVER THE COUNTER MEDICATION

The AdSS shall cover an over-the-counter (OTC) medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication when it is clinically appropriate, equally safe, effective, and more cost effective than the covered prescription medication.

E. PRESCRIPTION DRUG COVERAGE, BILLING LIMITATIONS AND PRESCRIPTION DELIVERY

1. The AdSS shall not cover a new prescription or refill prescription in excess of a 30-day supply unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 90-day supply;
   b. The Member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 90 days; or
   c. The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.
2. The AdSS shall provide prescription drugs for covered transplant services in accordance with AdSS Medical Policy Manual Policy 310-DD.
3. The AdSS shall cover the following for Members who are eligible to receive Medicare:
   a. OTC medications that are not covered as part of the Medicare Part D prescription drug program and the drug

meets the requirements in Section (D) of this policy;

b. A drug that is excluded from coverage under Medicare Part D by the Centers For Medicare and Medicaid Services (CMS) and the drug is medically necessary and Federally reimbursable; and

c. Cost sharing for medications to treat behavioral health conditions for individuals with an SMI designation.

4. The AdSS shall not allow pharmacies to charge a Member the cash price for a prescription, other than an applicable copayment, when the medication is Federally and State reimbursable and the prescription is ordered by an AHCCCS registered prescribing clinician.

5. The AdSS shall not allow pharmacies to split-bill the cost of a prescription claim to the AdSS PBMs for Members.

6. The AdSS PBMs pharmacies shall not allow a Member to pay cash for a partial prescription quantity for a Federally and State reimbursable medication when the ordered drug is written by an

AHCCCS registered prescribing clinician.

7. The AdSS shall communicate to the pharmacies that they are prohibited from auto-filling prescription medications.

8. The AdSS shall not allow pharmacies to submit prescription claims for reimbursement in excess of the Usual and Customary Price (U&C Price) charged to the general public.

9. The AdSS shall ensure that the sum of charges for both the product cost and dispensing fee does not exceed a pharmacy's U&C Price for the same prescription.

10. The AdSS shall ensure that the U&C Price submitted ingredient cost is the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the Member to enroll or pay a fee to join the program.

11. The AdSS shall require pharmacies that purchase drugs at a Nominal Price outside of 340B or the FSS to bill their Actual Acquisition Cost (AAC) of the drug.

F. PA REQUIREMENTS FOR LONG-ACTING OPIOID MEDICATIONS

1. The AdSS, AdSS' PBM or AHCCCS' PBM, as applicable, shall require the prescriber to obtain PA for all long-acting opioid prescription medications unless the Member's diagnosis is one the following:
    a. Active oncology diagnosis with neoplasm related pain;
    b. Hospice care; or
    c. End of life care (other than hospice).
2. The AdSS, AdSS' PBM or AHCCCS' PBM as applicable, shall require the prescriber to obtain their approval or an exception for all long-acting opioid prescription medications.

G. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS UNDER 18 YEARS OF AGE

1. The AdSS shall require a prescriber to limit the initial and refill prescriptions for any short-acting opioid medication for a Member under 18 years of age to no more than a 5-day supply, except as otherwise specified in Section (G) (2) below,

"Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The AdSS shall abide by the following Conditions and Care Exclusions from the 5-day Supply Limitation:
   a. The initial and refill prescription 5-day supply limitation for short- acting opioid medications does not apply to prescriptions for the following conditions and care instances:
      i. Active oncology diagnosis;
      ii. Hospice care;
      iii. End-of-life care (other than hospice);
      iv. Palliative Care;
      v. Children on an opioid wean at the time of hospital discharge;
      vi. Skilled nursing facility care;
      vii. Traumatic injury, excluding post-surgical procedures;
      viii. Chronic conditions for which the provider has received PA approval through the AdSS;

b. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, Initial Prescriptions for Short-Acting Opioid Medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

H. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS 18 YEARS OF AGE AND OLDER

1. The AdSS shall require a prescriber to limit the initial prescription for any short-acting opioid medication for a Member 18 years of age and older to no more than a 5-day supply, except as otherwise specified in Section (H) (2) below, "Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The AdSS shall abide by the following Conditions and Care Exclusions from the 5-day Initial Supply Limitation:

a. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

i. Active oncology diagnosis;

ii. Hospice care;

iii. Palliative Care;

iv. Skilled nursing facility care;

v. Traumatic injury, excluding post-surgical procedures;

vi. Post-surgical procedures; and

vii. The medication is for SUD treatment.

b. Initial Prescriptions for Short-Acting Opioid Medications for post-surgical procedures are limited to a supply of no more than 14 days.

I. ADDITIONAL FEDERAL OPIOID LEGISLATION MONITORING REQUIREMENTS

1. The AdSS shall implement automated processes to monitor the following opioid safety edits at the POS:

a. A 5 days supply limit for opioid naïve members;

b. Quantity limits;

c. Therapeutic duplication limitations;

d. Early fill limitations;

e. Opioid naïve Members prescribed an opioid, and the Morphine Equivalent Daily Dose (MEDD) is 50 or greater;

f. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90 and the Member is not opioid naive;

g. Members with concurrent use of an opioid in conjunction with a benzodiazepine or an antipsychotic;

h. Members are prescribed an opioid after being prescribed drugs used for MOUD for an Opioid Use Disorder (OUD);

i. OUD diagnosis;

j. Antipsychotic prescribing for children;

k. Fraud, Waste, and Abuse by enrolled Members,

pharmacies, and prescribing clinicians; and

l. Prospective and retrospective opioid reviews.

2. The AdSS shall report Drug Utilization Review management activities annually to the Division.

3. The AdSS shall allow a health care professional to write for a prescription that is more than 90 Morphine Milligram Equivalents (MME) per day if the prescription is:

a. A continuation of a prior prescription order issued within the previous 60 days;

b. An opioid with a maximum approved total daily dose in the labeling as approved by the U.S. Food and Drug Administration (FDA);

c. For a Member who has an active oncology diagnosis or a traumatic injury;

d. Receiving opioid treatment for perioperative surgical pain;

e. For a Member who is hospitalized;

f. For a Member who is receiving hospice care, end-of-life

care, palliative care, skilled nursing facility care or treatment for burns;

g. For a Member who is receiving MAT for a substance use disorder; or

h. For chronic intractable pain.

J. NALOXONE

1. The AdSS shall cover and consider Naloxone as an essential prescription medication to reduce the risk and prevent an opioid overdose death.

2. The AdSS shall require a prescription, ordered by an AHCCCS registered provider, be on file at the pharmacy when Naloxone is dispensed to or for a specific Member.

3. The AdSS shall adhere to the following process:

   a. Have a Standing Order written by the Director of the Arizona Department of Health Services on file at all Arizona pharmacies.

b. Identify the following eligible candidates that may obtain Naloxone:

i. Members who use illicit or non-prescription opioids with a history of such use;

ii. Members who have a history of opioid misuse, intoxication, or a recipient of emergency medical care for acute opioid poisoning;

iii. Members who have been prescribed high dose opioid prescriptions of 90 MEDD or less if there are other risk factors;

iv. Members who have been prescribed an opioid with a known or suspected concurrent alcohol use;

v. Members who are from opioid detoxification and mandatory abstinence programs;

vi. Members who have been treated with methadone for addiction or pain;

vii. Members who have an opioid addiction and smoking or Chronic Obstructive Pulmonary Disease (COPD) or other respiratory illness or obstruction;

viii. Members who have been prescribed opioids who also have renal, hepatic, cardiac, or HIV/AIDs (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) disease;

ix. Members who have difficulty accessing emergency services;

x. Members who have been assigned to a pharmacy or prescribing clinician;

xi. Members who voluntarily request Naloxone and are the family member or friend of a Member at risk of experiencing an opioid related overdose; and

xii. Members who voluntarily request Naloxone and are in the position to assist a Member at risk of experiencing an opioid related overdose.

4. The Adss shall cover:
    a. Naloxone Solution plus syringes,
    b. Naloxone Nasal Spray known as Narcan Nasal Spray, and
    c. Refills of the above Naloxone products on an as needed basis.

5. The AdSS shall require the pharmacy to educate every Member on the use of Naloxone by the pharmacist dispensing the medication in accordance with Arizona State Board of Pharmacy Regulations.

K. PHARMACY BENEFIT EXCLUSIONS

1. The AdSS shall treat the following pharmacy benefits as excluded and shall not be covered:
    a. Medications prescribed for the treatment of a sexual or erectile dysfunction, unless:
        i. The medication is prescribed to treat a condition other than a sexual or erectile dysfunction, and

ii. The FDA has approved the medication for the specific condition.

b. Medications that are personally dispensed by a physician, dentist, or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed;

c. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the FDA;

d. Outpatient medications for Members under the Federal Emergency Services Program, except for dialysis related medications for extended services individuals;

e. Medical Marijuana;

f. Drugs eligible for coverage under Medicare Part D for Members eligible for Medicare whether or not the Member obtains Medicare Part D coverage except for Dual Eligible Members that have creditable coverage or individuals with

an SMI designation;

g. Experimental medications as specified in A.A.C. § 9-22-203;

h. Medications furnished solely for cosmetic purposes;

i. Medications used for weight loss treatment; or

j. Complementary and Alternative Medicines.

L. RETURN OF AND CREDIT FOR UNUSED MEDICATIONS

1. The AdSS shall require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge, or death of a Member.

2. The AdSS shall have the outpatient pharmacy issue a payment or credit reversal to the AdSS or the AdSS PBM for unused prescription medications. The pharmacy may charge a restocking fee when agreed upon with AHCCCS and the Division or AdSS.

3. The AdSS shall require the return of unused prescription medication in accordance with Federal and State laws.

4. The AdSS shall maintain documentation and include the quantity of medication dispensed and utilized by the Member.

5. The AdSS shall issue a credit to AHCCCS if the Member is enrolled in the THP, TRBHA, or FFS Program, to the Member's AdSS for Members who are not FFS when the unused medication is returned to the pharmacy for redistribution.

M. DISCARDED PHYSICIAN-ADMINISTERED MEDICATION

1. The AdSS shall be billed for the discarded portion of Federally and State reimbursable physician-administered drugs that are unit-dose or unit-of-use designated products in MediSpan or First DataBank.

2. The AdSS shall ensure prescribers use the most cost-effective product(s) for the required dose to be administered.

3. The AdSS shall not allow billing from the prescriber or reimburse

the prescriber for any use or discarded portion of a unit-of-use or unit dose Repackaged drugs.

4. The AdSS shall ensure that for multidose products, prescribers only bill for the actual amount of drug that was used and the AdSS shall only reimburse the actual amount of used drug.

N. PA CRITERIA FOR SMOKING CESSATION AIDS

The AdSS shall follow the AHCCCS established PA criteria for tobacco cessation aids.

O. VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO INDIVIDUALS THREE YEARS OF AGE AND OLDER

1. The AdSS shall cover vaccines and Emergency Medication without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and A.R.S. § 32-1974.

2. The AdSS shall ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, shall only administer influenza and COVID immunizations to Members who are at least three years of age through 18 years of age.

3. The AdSS shall ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, administer AHCCCS covered immunizations to adults at least 18 years and older as specified in A.R.S. § 32-1974.

4. The AdSS shall ensure the pharmacies providing the vaccine are an AHCCCS registered provider.

5. The AdSS shall retain the discretion to determine the coverage of vaccine administration by pharmacists, pharmacy interns and technicians under the supervision of a pharmacist and that coverage is limited to the AdSS network pharmacies unless otherwise directed by AHCCCS.

P. 340B COVERED ENTITIES AND CLAIM SUBMISSION

1. The AdSS shall ensure that 340B covered entities submit the AAC of the drug for Member's POS prescription and physician-administered drug claims that are identified on the 340B pricing file, whether or not the drugs are purchased under the 340B Drug Pricing Program.

2. The AdSS shall reimburse POS claims at the lesser of:
   a. The AAC, or
   b. The 340B Ceiling Price, and
   c. A Professional Fee (dispensing fee).

3. The AdSS shall ensure physician administered drugs are reimbursed at the lesser of the AAC or the 340B ceiling price, and the Professional (dispensing) Fee is not reimbursed and is not permitted when a physician administered drug is administered by the prescribing clinician.

4. The AdSS shall not reimburse 340B Contracted Pharmacies for drugs that are purchased, dispensed, or administered as part of

or subject to the 340B Drug Pricing Program.

5. The AdSS shall comply with any changes to reimbursement methodology for 340B entities.

Q. PHARMACEUTICAL REBATES

1. The AdSS, including the THP PBM and AdSS' PBM, shall be prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product.

2. The AdSS or its PBM's shall consider outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, to be exempt from such rebate agreements if they have an existing rebate agreement with a manufacturer.

R. INFORMED CONSENT

1. The AdSS shall ensure the prescriber obtains informed consent from the Responsible Person for each psychotropic medication

prescribed.

2. The AdSS shall ensure that prescribers are documenting the essential elements for obtaining informed consent in the comprehensive clinical record, utilizing AMPM Attachment 310-V (A).

S. YOUTH ASSENT

1. The AdSS shall ensure prescribers educate youth under the age of 18 on options, are allowed to provide input, and are encouraged to assent to medications being prescribed.

2. The AdSS shall ensure prescribers discuss this information with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth.

3. The AdSS shall ensure prescribers share information with Members who are under the age of 18 that is consistent with the information shared in obtaining informed consent from adults.

4. The AdSS shall ensure the prescribers obtain informed consent

for a minor through the minor's authorized Responsible Person unless the minor is emancipated.

5. The AdSS shall ensure prescribers discuss the youth can give consent for medications when they turn 18.

6. The AdSS shall begin the discussion about consent for medication no later than age 17½ years old, especially for youth who are not in the custody of their parents.

7. The AdSS shall ensure prescribers address the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements, and other health parameters.

8. The AdSS shall ensure the prescribers document evidence of the youth's consent to continue medications after their 18th birthday through use of AMPM Attachment 310-V (A).

T. PRESCRIPTION DRUG COUNSELING

The AdSS shall communicate to the pharmacy network that

pharmacists, and graduate and non-graduate pharmacy interns, under the supervision of a pharmacist are to provide counseling on prescription drugs, prescribed and dispensed to AHCCCS members, in accordance with the Arizona State Board of Pharmacy A.A.C. 4-23-402.

SUPPLEMENTAL INFORMATION

1. A controlled substance is defined in A.R.S. § 32-3248.01. For opioid prescribing guidelines refer to the Arizona Opioid Epidemic Act.
2. The AdSS covers medically necessary, cost-effective and federally and State reimbursable medications and devices for Members as prescribed or administered by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner with prescriptive authority in the State of Arizona and dispensed by an AHCCCS registered licensed pharmacy pursuant to 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2, and for persons with a SMI

designation, pursuant to A.R.S. § 36-550.

3. Generic and Biosimilar substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.

4. Arizona 340B entity hospitals, and outpatient facilities owned and operated by a 340B entity hospital, are not exempt from the reimbursement methodology listed in Section (P) (2).

5. Effective with a future date to be determined, 340B hospitals and outpatient facilities, owned and operated by a 340B hospital, shall be required to submit claims at the entity's AAC.

6. The provider shall use the most cost-effective product(s) for the required dose to be administered. For example, if the dose to be administered is 12mg and the product is available in a 10mg and 50mg vial, the provider shall use two - 10mg vials to obtain the 12mg dose. The 12mg dose shall be billed as the administered dose and 8mg shall be billed as discarded waste using the JW modifier.

7. Effective 01/01/22, repackaged medications are not Federally

and State reimbursable.

8. Mental Health Block Grant (MHBG) provisions shall apply to Children with Serious Emotional Disturbance (SED), Individuals in First Episode Psychosis (FEP), and Adults with SMI designation. For individuals with a Substance Use Disorder (SUD), Substance Abuse Block Grant (SABG) provisions shall apply.

9. The AHCCCS Pharmacy and Therapeutics (P&T) Committee is responsible for developing, managing, and updating the AHCCCS Drug List to assist providers in selecting clinically appropriate and cost-effective drugs or devices for Members.

10. The AHCCCS Drug List is not an all-inclusive list of medications for Members.

11. The AHCCCS P&T Committee shall make recommendations to the AdSS on the Grandfathering status of each Non-Preferred Drug for each therapeutic class reviewed by the committee.

12. The AHCCCS Drug List specifies which medications require PA

prior to dispensing the medication.

13. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated that typically require the use of a more cost effective drug that is safe and effective to be used prior to approval of a more costly medication.

14. Guest dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support.

15. Pharmacies, at their discretion, may deliver or mail prescription medications to a Member or to an AdSS registered provider's office for a specific Member.

The Sending OTP Center

1. The Sending OTP Center shall forward information to the Receiving OTP Center prior to the Member's arrival, information shall include:
    a. A valid release of information signed by the Member;
    b. Current medications;

c. Date and amount of last dose administered or dispensed;

d. Physician order for Guest Dosing, including first and last dates of Guest Dosing;

e. Description of clinical stability including recent alcohol or illicit drug Abuse; and

f. Any other pertinent information.

2. The Sending OTP Center shall provide a copy of the information to the Member in a sealed, signed envelope for the Member to present to the Receiving OTP Center.

3. The Sending OTP Center shall submit notification to the AdSS of enrollment of the Guest Dosing arrangement.

4. The Sending OTP Center shall accept the Member upon return from the Receiving OTP Center unless other arrangements have been made.

The Guest OTP Center

1. The Guest OTP Center shall:

a. Respond to the Sending OTP Center in a timely fashion,

verifying receipt of information and acceptance of the Member for guest medication as quickly as possible;

b. Provide the same dosage that the Member is receiving at the Member's Sending OTP Center, and change only after consultation with Sending OTP Center;

c. Bill the Member's Contractor of enrollment for reimbursement utilizing the appropriate coding and modifier;

d. Provide address of Guest OTP Center and dispensing hours;

e. Determine appropriateness for dosing prior to administering a dose to the Member. The Guest OTP Center has the right to deny medication to a Member if they present inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with other Members;

f. Communicate any concerns about a guest-dosing the

Member to the Sending OTP Center including termination of guest-dosing if indicated; and

g. Communicate the last dose date and amount back to the Sending OTP Center.

Signature of Chief Medical Officer: Anthony Dekker (Jan 18, 2024 17:39 MST)
Anthony Dekker, D.O.

310-BB TRANSPORTATION FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: February 22, 2023
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211, A.A.C.n A.A.C. R9-22-211, AMPM 310, AMPM 310-BB, AMPM 320-I, AMPM 700

PURPOSE

This policy describes requirements for coverage of transportation services for Division of Developmental Disabilities (DDD) members who are eligible for Arizona Long Term Care System (ALTCS). This policies applies to DDD's Administrative Services Subcontractors (AdSS)

DEFINITIONS

1. "Alternative Destination Partner" means an Arizona Health Care Cost Containment System (AHCCCS) registered provider, such as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC), primary care provider doctor, specialist, behavioral health center or urgent care clinic.

2. "Certificate of Necessity (CON)" means regulations that require healthcare providers to get special permission from the

government before adding or expanding healthcare services or facilities.

3. "Emergency Transportation" means ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
   a. Placing the member's health in serious jeopardy, or
   b. Serious impairment of bodily functions, or
   c. Serious dysfunction of any bodily organ or part, or
   d. Serious physical harm to self or another individual.

4. "Emergency Triage, Treat, and Transport", "ET3" means a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation

providers to address a member's health care needs following a 9-1-1 call. ET3 permits Emergency Transportation providers to transport a member to the nearest appropriate AHCCCS-registered facility, and to initiate and facilitate a members' receipt of medically necessary covered service(s) at the scene of a 9-1-1 response either in-person on the scene or via telehealth.

5. "Maternal Transport Program (MTP)"/" Newborn Intensive Care Program (NICP)" means programs that are administered by the ADHS that provide special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center.

POLICY

A. EMERGENCY TRANSPORTATION

1. The AdSS shall cover Emergency Transportation in emergent situations in which ambulance transportation (specially staffed and equipped) is required to safely manage the member's condition.

2. The AdSS may cover basic life support, advanced life support, and air ambulance services are covered, depending upon the member's medical needs.
3. The AdSS shall cover emergency transportation for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
    a. Placing the member's health in serious jeopardy,
    b. Serious impairment of bodily functions,
    c. Serious dysfunction of any bodily organ or part, or
    d. Serious physical harm to another person (for behavioral health conditions).
4. The AdSS shall not require prior authorization for emergency transportation.
5. The AdSS shall cover Emergency Transportation that coverage also includes the transportation of a member to a higher level of care for immediate medically necessary treatment, including when occurring after stabilization at an emergency facility.

6. The AdSS shall cover emergency medical transportation only to the nearest appropriate AHCCCS-registered facility capable of meeting the member's physical and behavioral health needs.
7. The AdSS shall cover Emergency Transportation to obtain immediate treatment for acute conditions including, but not limited to the following:
    a. Untreated fracture or suspected fracture of spine or long bones;
    b. Severe head injury or coma;
    c. Serious abdominal or chest injury;
    d. Severe hemorrhage;
    e. Serious complications of pregnancy;
    f. Shock, heart attack or suspected heart attack, stroke or unconsciousness;
    g. Uncontrolled seizures; or
    h. Condition warranting use of restraints to safely transport to medical care.

B. AIR AMBULANCE

1. Prior Authorization is not required of any non-emergent medically necessary air ambulance transport services, regardless of the miles.
2. The Division shall cover air ambulance services under the any of the following conditions:
   a. The air ambulance transport is initiated at the request of:
      i. Emergency response unit,
      ii. Law enforcement official,
      iii. Clinic or hospital medical staff member, or
      iv. Physician or practitioner.
   b. The point of pickup is:
      i. Inaccessible by ground ambulance,
      ii. There is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance will not suffice, or
      iii. The medical condition of the member requires

immediate intervention of emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.

3. The Division shall ensure that air ambulance companies are licensed by the Arizona Department of Health Services (ADHS) and be registered as a provider with AHCCCS.

C. EMERGENCY TRIAGE, TREAT AND TRANSPORT PROGRAM (ET3)

1. The Division shall cover the Emergency Triage, Treat, and Transport Program (ET3) when an Emergency Transportation provider responds to a "9-1-1", fire, police, or other locally established system for emergency calls.
2. The Division shall require the Emergency Transportation provider be AHCCCS-registered and have a Certificate of Necessity (CON) from ADHS; or are tribal providers who have a signed AHCCCS attestation of CON equivalency in order to transport a member to an appropriate AHCCCS-registered provider or provide treatment to the member on the scene.

3. The Division shall cover Emergency Transportation to an appropriate AHCCCS-registered provider when the emergency response team's field evaluation of the member shows the services are medically necessary but not emergent, when the following conditions are met:
    a. Transport to an Alternative Destination Partner will meet the member’s level of care more appropriately than transport to an emergency department;
    b. The appropriate AHCCCS-registered provider is within or near the responding Emergency Transportation provider’s services area;
    c. The Emergency Transportation provider has a pre-established arrangement with the AHCCCS-registered provider located within their region; and
    d. The Emergency Transportation provider has knowledge of the AHCCCS-registered provider’s:
        i. Hours of operation;
        ii. Clinical Staff available;

iii. Services provided; and

iv. Ability to arrange transportation for the member to return home, as needed.

4. The Division shall cover emergency treatment on the scene when:

a. The emergency response team's evaluation of the member shows that services are medically necessary but not emergent;

b. The Emergency Transportation provider treats the member in accordance with the provider's scope of practice and their emergency transport service's medical direction, including the use of telehealth/telemedicine when medically indicated.

D. EMERGENCY TRANSPORTATION PROVIDER REQUIREMENTS FOR EMERGENCY TRANSPORTATION SERVICES PROVIDED TO MEMBERS LIVING ON TRIBAL LANDS

1. The Division shall require that, in addition to other requirements specified in this policy, Emergency Transportation providers

rendering services on tribal lands must meet the following requirements:

a. The Division shall cover Emergency Transportation services to manage an emergency physical or behavioral health condition at the emergency scene and in transport to the nearest appropriate facility capable of meeting the member's health care needs.

E. MEDICALLY NECESSARY NON-EMERGENCY TRANSPORTATION FOR MEDICAL AND BEHAVIORAL HEALTH SERVICES

1. The Division shall cover medically necessary, Non-Emergency Transportation when furnished by Non-Emergency Transportation providers to transport the member to and from a covered physical or behavioral service. Such transportation services may also be provided by Emergency Transportation providers after assessment by the Emergency Transportation team or paramedic team that the team determines the member's condition requires medically necessary transportation. Medically necessary Non-Emergency Transportation is also referred to as

Non-Emergency Medical Transportation (NEMT).

2. The Division shall cover medically necessary Non-Emergency Transportation services under the following conditions:
   a. The physical or behavioral health service for which the transportation is needed, is a service covered by the Division;
   b. The member is not able to provide, secure, or pay for their own transportation, and free transportation is not available; and
   c. The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.
3. The Division shall also cover Non-Emergency Transportation services are also covered under the following circumstances:
   a. Transport a member to obtain their Medicare Part D covered prescriptions.
4. The Division shall cover medically necessary Non-Emergency Transportation services furnished by all providers who offer transportation for members residing within the State of Arizona

limited to trips within 100 miles of the pick-up location when traveling to a pharmacy. For those members living in Maricopa and Pinal counties the travel mileage to a pharmacy is limited to 15 miles. Mileage is calculated from the pick-up location to the drop off location, one direction. Trips over 100 miles require authorization from the Division. NEMT trips for members traveling to Multi-Specialty Integrated Clinics (MSIC) or IHS/638 facilities are exempt from this limitation.

5. The Division shall cover NEMT for members residing within the State of Arizona limited to trips within 100 miles of the pick-up location when traveling to a pharmacy. For those members living in Maricopa and Pinal counties the travel mileage to a pharmacy is limited to 15 miles. Mileage is calculated from the pick-up location to the drop off location, one direction. Trips over 100 miles require authorization from the Division. NEMT trips for members traveling to Multi-Specialty Integrated Clinics (MSIC) or IHS/638 facilities are exempt from this limitation.
6. The Division shall cover non-Emergency Transportation of a

family member or caregiver without the presence of the member when provided for the purpose of carrying out medically necessary services identified in the member's service/treatment plan.

7. The Division shall covers medically necessary Non-Emergency Transportation provided by ambulance providers when:
   a. Other methods of transportation are contraindicated, this must be documented;
   b. The medical condition (regardless of bed confinement) of the member requires the medical treatment be provided by qualified staff in an ambulance;
   c. For hospitalized members only:
      i. The member must not require medical care enroute;
      ii. Passenger occupancy must not exceed the manufacturer's specified seating occupancy;
      iii. Members, companions, and other passengers must follow state laws regarding passenger restraints for adults and children;

iv. Vehicle must be driven by a licensed driver, following applicable State laws;

v. Vehicles must be insured;

vi. Vehicles must be in good working order;

vii. Members, companions, and other passengers must be transported inside the vehicle; and

viii. School-based providers should follow the school-based policies in effect.

8. The Division may cover the cost of Non-Emergency Transportation, if medically necessary, provided by a non-ambulance air or equine NEMT provider only when all of the following conditions are met:

   a. The service is exclusively used to transport the member to ground accessible transportation;

   b. The member's point of pick-up or return is inaccessible by ground transport; and

   c. Ground transport is not accessible because of the nature and extent of the surrounding rural/tribal

terrain.

9. The Division shall cover Non-Emergency Transportation when medically necessary and furnished by ambulance providers when the following conditions are met:
   a. The Division shall cover round trip air or ground transportation services if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic and/or therapeutic services, such as chemo, MRI, Cobalt therapy.
   b. The Division shall cover the cost of the transportation if the services are not available in the hospital in which the member is hospitalized.
10. The Division shall ensure public transportation is available as an option to a member when it is available within the service area and NEMT services are requested and is limited to AHCCCS approved services. The following shall be considered when offering public transportation:
   a. Location of the member to a transportation stop;

b. Location of the Provider and/or AHCCCS approved services to a transportation stop;

c. Coordination of the member's appointment with the public transportation schedule;

d. Ability of the member to travel alone on public transportation; or

e. Member preference.

F. MATERNAL AND NEWBORN TRANSPORTATION

1. The Division shall cover medically necessary maternal and newborn transportation through the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP).

Signature of Chief Medical Officer: Anthony Dekker (Feb 14, 2023 15:08 MST)
Anthony Dekker, D.O.

310-DD COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS

REVISION DATE: 4/26/2023, 3/1/2023, 10/1/2019
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907; A.R.S. § 36-850.01; A.A.C. R9-22-101; A.A.C. R9-22-202; A.A.C. R9-22-203; A.A.C. R9-22-206; 42 U.S.C. 1396b (i) and 42 CFR 441.35; AHCCCS Medical Policy 310-DD, Attachment A

PURPOSE

The purpose of this policy is to outline the coverage for transplants, related services, and immunosuppressant medications for Division members who are enrolled with an Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Behavioral Health Professional" or "BHP" means
    a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as

defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,

b. A psychiatrist as defined in A.R.S. §36-501,

c. A psychologist as defined in A.R.S. §32-2061,

d. A physician,

e. A behavior analyst as defined in A.R.S. §32-2091,

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

g. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services

2. “Close Proximity” means within the geographic service area.

3. “Disability” means a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

4. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for

medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Experimental Service" means a service which is not generally and widely accepted as a Standard of Care in the practice of medicine in the United States and is not a safe and effective treatment for the condition for which it is intended or used as specified in A.A.C. R9-22-203.

6. "Foundation for the Accreditation of Cellular Therapy" or "FACT" is a Non-profit corporation co-founded by the International Society for Cellular Therapy (ISCT) and the American Society of Blood and Marrow Transplantation (ASBMT) for the purposes of voluntary inspection and accreditation in the field of cellular therapy.

7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Organ Procurement and Transplantation Network" or "OPTN" is a public-private partnership operated through the United States Department of Health and Human Services and established

through the National Organ Transplant Act (NOTA). The OPTN policies govern operation of all Member transplant hospitals, Organ Procurement Organizations (OPOs) and histocompatibility labs in the United States.

9. "Standard of Care" means a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community" (A.A.C. R9-22- 101).

10. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

11. "United Network for Organ Sharing" or "UNOS" means a private, non-profit organization that manages the nations' organ transplant system under contract with Organ Procurement and

Transplantation Network, including managing the national transplant Waiting List and maintaining the database that contains all organ transplant data for every transplant event that occurs in the United States.

12. "Waiting List" as defined by OPTN, is a computerized list of candidates who are waiting to be matched with specific deceased donor organs for transplant.

POLICY

A. GENERAL INFORMATION

1. The AdSS shall follow all Federal, State and Arizona Health Care Cost Containment System (AHCCCS) requirements for coverage of transplants, related services, and immunosuppressant medications.

B. COVERED TRANSPLANTS

1. The AdSS shall ensure coverage of the following transplant types for Members aged 21 and older:
   a. Heart;
   b. Single lung and double lung;

c. Heart-Lung;

d. Liver;

e. Cadaveric kidney and living donor kidney;

f. Simultaneous Liver and Kidney;

g. Simultaneous Pancreas and Kidney;

h. Pancreas after Kidney; and

i. Allogeneic related Hematopoietic Stem Cell Transplants:

i. Allogeneic related,

ii. Allogeneic unrelated,

iii. Autologous, and

iv. Tandem Hematopoietic Stem Cell Transplant.

2. The AdSS shall ensure Members under the age of 21 under the EPSDT Program are referred or put on the Waiting List for medically necessary services to correct or ameliorate defects, illnesses, and physical conditions. Transplants for EPSDT Members are covered when medically necessary irrespective of whether the particular non-experimental transplant is specified as covered in the AHCCCS State Plan.

3. The AdSS shall ensure that transplants are medically necessary, non-experimental, and federally reimbursable, state reimbursable, and fall within the medical Standard of Care for coverage.
4. The AdSS shall ensure national standards for transplantation which include policy for:
    a. Organ Procurement Transplant Network,
    b. Centers for Medicare and Medicaid Services (CMS),
    c. United Network for Organ Sharing, and
    d. Foundation for the Accreditation of Cellular Therapy.
5. The AdSS shall cover Circulatory Assist Devices (CADs), including Left Ventricular Assist Devices (LVADs) services for destination therapy and as a bridge to transplant when medically necessary and non-experimental.
6. The AdSS shall cover corneal transplants and bone grafts when medically necessary, cost effective and non-experimental as specified in AMPM Exhibit 300-1.

7. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant medications prior to denying services.
8. Any AdSS network provider who requests authorization for a service shall be notified of the option to request a peer-to-peer discussion with the AdSS Medical Director when additional information is requested by the Division or when a PA request is denied.

C. COVERED TRANSPLANT SERVICES

1. The AdSS shall cover the following services, as required by the specific type of transplant:
    a. Inpatient or outpatient pre-transplant evaluation, which includes, but is not limited to, the following:
        i. Physical examination,
        ii. Psychological evaluation,
        iii. Laboratory studies,
        iv. Radiology and diagnostic imaging or procedures, and
        v. Biopsies.

b. Donor search, Human Leukocyte Antigen (HLA) typing, and harvest as necessary for hematopoietic transplants

c. Pre-transplant dental evaluation and treatment

d. Transplantation

e. Inpatient or outpatient post-transplant care, which may include, but is not limited to, the following:

   i. Laboratory studies

   ii. Radiology and diagnostic imaging or procedures

   iii. Biopsies

   iv. Home health

   v. Skilled nursing facility services

f. All related medications, including transplant related immunosuppressants medications, as specified in AMPM 310-V.

g. Transportation, and room and board for the transplant candidate, donor and, if needed, one adult caregiver as identified by the transplant facility.

i. Coverage is limited to medical treatment transportation, to and from the facility, during the time it is necessary for the Member to remain in Close Proximity to the transplant center.

ii. Coverage includes the periods of evaluation, on-going testing, transplantation, and post-transplant care by the transplant center.

2. The AdSS shall ensure the Living Donor Coverage which is limited to the following when provided in the United States:

a. Evaluation and testing for suitability;

b. Solid organ or hematopoietic stem cell procurement, processing, and storage; and

c. Transportation and lodging when it is necessary for:

i. The potential donor to travel for testing to determine if they are a match, and

ii. Donating either stem cells or organs.

D. CONDITIONS FOR TRANSPLANTATION

1. The AdSS shall ensure the following conditions are met for transplantation:
    a. Transplant candidates meet the criteria to be added to the Waiting List.
    b. Medical comorbidities are assessed through history and physical with a plan developed for appropriate care and ensure the following:
        i. Changes in medical conditions shall be assessed for the impact upon transplant candidacy.
        ii. All transplant candidates shall undergo routine age-condition appropriate screening for disease.
    c. Identified indolent or chronic infections have a plan of containment in accordance with an infectious disease specialist's recommendation.
    d. Members with identified neoplasms are assessed in accordance with an oncologist's recommendations.
    e. Psychosocial environment is assessed, and appropriate plans are generated to mitigate issues of adherence.

f. Behavioral Health Treatment Plans are developed with a BHP for Members with prior or ongoing adherence issues that might impact their ability to adhere to the transplantation care plan, based on a BHP assessment.

g. Members with substance use disorder(s) have:

i. Plans for treatment before and after the organ replacement; and

ii. Consultation with a BHP who will work as a part of the treatment team to support the Member needs and maintain wellness and recovery oriented treatment, services and supports.

E. TRANSPLANT SERVICES AND SETTINGS

1. The AdSS shall cover solid organ transplant services provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers as specified in 42 CFR Part 482.

2. The AdSS shall cover hematopoietic stem cell transplant services provided in a facility that has achieved FACT accreditation. The facility shall meet the Medicare conditions for participation and any additional federal requirement for transplant facilities.
3. The AdSS shall ensure reimbursement is only available for transplant centers that meet the above requirements.

F. ADDITIONAL REQUIREMENTS

1. The AdSS shall ensure coverage of out-of-network solid organ or hematopoietic stem cell transplants that meet the following requirements:
    a. Services are covered for Members who have current medical requirements that cannot be met by an AHCCCS contracted transplant center.
    b. Medical requirements for an out-of-network transplant request are clearly documented, specifying the level of technical expertise or program coverage that is not provided at an AHCCCS contracted facility.

c. The AdSS reviews the quality and outcome data published for the out-of-network facility as part of secondary review.

2. The AdSS shall cover solid organ living donor-related costs for pediatric kidney and liver transplants and adult kidney transplants.

3. The AdSS shall cover living donor transplants on a case-by-case basis for solid organs other than pediatric and adult kidney and pediatric liver when medically necessary and cost effective.

   a. Payment is limited for solid organ living donors other than pediatric and adult kidney and pediatric liver to the surgical procedure and follow-up post-op care provided to the donor through post-op day three.

   b. For any additional charges, the living donor shall accept the terms of financial responsibility for the charges associated with the transplant that are in excess of the AHCCCS Specialty Contract for Transplantation Services.

4. The AdSS shall ensure limited coverage for medically necessary and non-Experimental Services following the discharge from the

acute care hospital where the non-covered transplant procedure was performed, if a Division Member receives a transplant that is not covered by AHCCCS guidelines.

a. Excluded services:

   i. Evaluations and treatments to prepare for transplant candidacy,

   ii. The actual transplant procedure and accompanying hospitalization, or

   iii. Organ or tissue procurement.

b. Covered services include:

   i. Transitional living arrangements appropriately ordered for post-transplant care when the Member does not live in Close Proximity to the transplant center,

   ii. Essential laboratory and radiology procedures,

   iii. Therapies that are medically necessary post-transplant,

   iv. Immunosuppressant medications, and

v. Transportation that is medically necessary post-transplant.

5. The AdSS shall utilize the AHCCCS Specialty Contract for Transplantation Services for second covered organ transplant performed during the follow-up care periods of the first transplant.
6. The AdSS shall utilize the AHCCCS Reinsurance Processing Manual for transplantation reinsurance standards.
7. The AdSS shall utilize the AHCCCS Specialty Contract for Transplantation Services for detailed information regarding transplant coverage and payment for transplant services and transplant related services.

G. TRANSPLANT CARE COORDINATION

1. The AdSS Transplant Coordinator shall coordinate with the Division's Transplant Coordinator at least quarterly and on an ad hoc basis to ensure Member's health services needs are being met and to ensure continuity of care.

2. The AdSS shall submit Division specific transplant logs on a quarterly basis for review and tracking.
3. The AdSS Transplant Coordinator shall ensure continuity of care for Members receiving care through Indian Health Services (IHS) who are being considered for transplant services.

H. ORGAN TRANSPLANT ELIGIBILITY

1. The AdSS shall not, solely on the basis of a Member's Disability, do any of the following:
    a. Determine that the Member is ineligible to receive an organ transplant,
    b. Deny the Member's medical or other services related to an organ transplant, including:
        i. Evaluation,
        ii. Surgery,
        iii. Counseling, and
        iv. Postoperative treatment.

c. Refuse to refer the Member to a transplant hospital or other related specialist for evaluation or receipt of an organ transplant,

d. Refuse to place the individual on an organ transplant Waiting List or place the Member at a position lower in priority on the list than the position the Member would be placed if not for the Member's Disability, and

e. Decline insurance coverage for the Member for any procedure associated with the receipt of an organ transplant or related services associated with the receipt of an organ transplant or for related services if the procedure or services would be covered under such insurance for the Member if not for the Member's Disability.

2. The AdSS shall not consider a Member's inability to independently comply with posttransplant medical requirements as medically significant if the Member has a known Disability and the necessary support system to assist the Member in reasonably complying with the requirements.

Signature of Chief Medical Officer: Anthony Dekker (Apr 21, 2023 12:34 PDT)
Anthony Dekker, D.O.

310-FF MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

REVISION DATE: 1/3/2024, 09/06/2023, 09/30/2020
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.54; 42 CFR 455.2; 42 USC 1396A(OO); 21 U.S.C § 802(6); A.A.C. R9-34-302; A.A.C. R9-43-202; A.A.C. Title 9, Chapter 34, Articles 2 and 3; AMPM 310-FF; AMPM 310-V; AMPM 520; AMPM 910; AMPM 1024; ACOM 103.

PURPOSE

This policy sets forth the requirements for monitoring controlled and non-controlled medication use and the requirements to ensure Members receive clinically appropriate prescriptions. This policy applies to the Division's Administrative Services Subcontractors (AdSS) that includes delegated health plans and pharmacy benefits manager.

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AdSS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also

includes beneficiary practices that result in unnecessary cost to the Division Program.

2. "Controlled Substance" means drugs and other substances that are defined as Controlled Substances under 21 U.S.C § 802(6).

3. "CSPMP" means the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program.

4. "Drug Diversion" means redirection of prescription drugs for illicit purposes.

5. "Emergencies" means medical services provided for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

   a. Placing the Member's health in serious jeopardy;

   b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part;

d. The medication is out-of-stock at the Exclusive Pharmacy; or

e. The Exclusive Pharmacy is closed.

6. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the AdSS to provide all medically necessary federally reimbursable pharmaceuticals to the Member.

7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable State or Federal law.

8. "Intervention" means for the purpose of this policy, the requirements to ensure Members receive clinically appropriate prescriptions.

9. "Member" means the same as "Client" as defined in A.R.S. §

36-551.

10. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. MONITORING REQUIREMENTS

1. The AdSS shall monitor controlled and non-controlled medications on an ongoing basis for any Member who has received one of the medications listed in Section (A)(4) through their health plan.

2. The AdSS shall monitor the evaluation of prescription use by Members, prescribing patterns by clinicians, and dispensing by pharmacies.

3. The AdSS shall use drug utilization data to identify and screen high-risk Members and providers who may facilitate Drug Diversion.

4. The AdSS shall identify monitoring requirements that determine potential misuse of the drugs used in the following therapeutic classes:
    a. Atypical Antipsychotics,
    b. Benzodiazepines,
    c. Hypnotics,
    d. Muscle Relaxants,
    e. Opioids, and
    f. Stimulants.

5. The AdSS shall use the following resources, when available for their monitoring activities:
    a. Prescription claims data;
    b. Controlled Substance Prescription Monitoring Program (CSPMP); and
    c. Pertinent data used for monitoring controlled and non-controlled medication utilization.

6. The AdSS shall monitor the prescription claims data quarterly to identify:

a. Medications filled prior to the calculated days-supply,

b. Number of prescribing clinicians,

c. Number of different pharmacies used by the Member, and

d. Other potential indicators of medication misuse.

B. DIVISION OVERSIGHT OF INTERVENTION REQUIREMENTS

1. The AdSS shall implement the following required Interventions to ensure Members receive the appropriate medication, dosage, quantity, and frequency:

   a. Provider education;

   b. Point-of-Sale (POS) safety edits and quantity limits;

   c. Care management;

   d. Assignment of Members who meet either of the following evaluation parameters listed below to an Exclusive Pharmacy, exclusive provider or both for up to a 12-month period:

      i. A Member using the following in a three-month time period:

a) Greater than four prescribers, and

b) Greater than four different Abuse potential drugs, and

c) Four Pharmacies; or

d) The Member has received 12 or more prescriptions of the medications listed in the Monitoring Requirements section in the past 3 months.

ii. A Member presenting a forged or altered prescription to the pharmacy.

2. The AdSS may implement additional interventions and more restrictive parameters for referral to, or coordination of care with behavioral health service providers or other appropriate specialists when the AdSS deems it necessary or beneficial to their Members.

3. The AdSS shall provide a written notice detailing the factual and legal basis based for the restriction, to any Member who has

been assigned to an exclusive provider or pharmacy or both for up to 12 months utilizing AMPM 310-FF, Attachment A.

4. The AdSS shall treat this restriction as an "action" pursuant to A.A.C. R9-43-202 and A.A.C. R9-34-302.

5. The AdSS shall provide the written notice that informs the Member of the opportunity to file an appeal to the restriction and the timeframes and process for doing so as described in A.A.C. Title 9, Chapter 34, Articles 2 and 3.

6. The AdSS shall not implement the restriction before providing the Member written notice of the restriction and the opportunity for an appeal or State fair hearing.

7. The AdSS shall not impose a restriction if the Member has filed an appeal until:
    a. The Medical Director of the AdSS' decision has affirmed the restriction;
    b. The Member has voluntarily withdrawn the appeal or request for hearing; or

c. The Member fails to file an appeal or request for hearing no later than 30 calendar days from the date of the notice.

8. The AdSS shall review the Member's prescription and other utilization data to determine whether the Intervention will be continued or discontinued at the end of the designated time period, which is no longer than every 12 months.

9. The AdSS shall notify the Member in writing of the decision to continue or discontinue the assignment of the pharmacy or provider.

10. The AdSS shall utilize AMPM 310-FF Attachment A to include instructions for the appeals or fair hearing process in the notification letter to the Member if the decision is to continue the assignment.

11. The AdSS shall not apply the Intervention of assigning an Exclusive Pharmacy or provider to emergency services furnished to the Member.

12. The AdSS shall ensure that the Member has reasonable access to

services, taking into account the geographic location and reasonable travel time.

13. The AdSS shall provide specific instructions to the Member, the assigned Exclusive Pharmacy or exclusive provider, and their Pharmacy Benefit Manager (PBM), on how to address Emergencies.

14. The AdSS may assign Members who meet any of the parameters in Section (B)(15) to a single prescriber in addition to the assignment to an Exclusive Pharmacy.

15. The AdSS shall not subject Members with one or more of the following conditions to the Intervention requirements described in Section (B)(1):
    a. Treatment for an active oncology diagnosis,
    b. Receiving hospice care, or
    c. Residing in a skilled nursing facility or intermediate care facility.

C. REPORTING REQUIREMENTS

1. The AdSS shall refer all identified cases of Member deaths due to medication poisoning, overdose or toxic substances to the Division's Quality Management department as an incident report for research and review.

2. The AdSS shall report all suspected Fraud, Waste, and Abuse to the appropriate entity, and copy the Division as specified in ACOM 103 and the contract with the Division.

3. The AdSS shall submit to the Division the number of Members on that day that are assigned to an Exclusive Pharmacy, or single prescriber, or both due to excessive use of prescription medications,controlled and non-controlled medications utilizing AMPM Attachment 1024-A.

4. The AdSS shall report to the Division, any material changes that the AdSS implements additional Interventions and more restrictive parameters as noted in this policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 29, 2023 10:24 MST)
Anthony Dekker, D.O.

310-GG NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTERAL NUTRITION

REVISION DATE: 2/7/2024, 6/7/2023
REVIEW DATE: 7/25/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 20-2327, AMPM Policy 310-GG, AMPM Policy 430, AMPM 520, AMPM Policy 820

PURPOSE

This policy describes coverage of and requirements for nutritional therapy, metabolic foods and Total Parenteral Nutrition (TPN) for Division of Developmental Disability (DDD) Members, 21 years of age and older, who are eligible for Arizona Long Term Care System (ALTCS). This policy applies to DDD's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Enteral Nutrition'' means liquid nourishment provided directly to

the digestive tract of a Member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral Nutrition is commonly provided by Jejunostomy Tube (J-Tube), Gastrostomy Tube (G-Tube) or Nasogastric (N/G Tube).

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Metabolic Medical Food Formulas" or "Medical Foods" means nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing substances that cannot be metabolized by the

Member.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

6. "Total Parenteral Nutrition", "TPN" means nourishment provided through the venous system to Members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

POLICY

A. NUTRITIONAL ASSESSMENT AND THERAPY

1. The AdSS shall require a nutritional assessment for a Member who has been identified as having a health status which may

improve or be maintained with nutritional interventions.

2. The AdSS shall cover the nutritional assessment as determined medically necessary and as a part of health risk assessment and screening services provided by the Member's Primary Care Provider (PCP).

3. The AdSS shall cover nutritional assessment services provided by a registered dietitian when ordered by the Member's PCP.

4. The AdSS shall cover nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a Member's daily nutritional and caloric intake.

5. The AdSS shall be responsible for the procurement of and the primary funding source for any other nutritional supplementation medically necessary for Women, Infants, and Children (WIC) exempt formula.

6. The AdSS shall implement protocols for transitioning a Member who is receiving nutritional therapy to or from subcontractors or

providers.

B. PRIOR AUTHORIZATION

1. The AdSS shall require Prior Authorization (PA) for commercial oral nutritional supplements, Enteral Nutrition, and Parenteral Nutrition unless:
   a. The Member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained, or
   b. For the first 30 days with Members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition, i.e. post-hospitalization.

C. COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

1. The AdSS shall require the Member's PCP or specialty provider to determine medical necessity for commercial oral nutritional supplements on an individual basis, using the criteria specified in this policy.

2. The AdSS shall require the PCP or specialty provider to use AMPM Attachment 310-GG (A) to obtain authorization from the Division.

3. The AdSS shall follow specific criteria utilizing AMPM Attachment 310-GG (A) when assessing the medical necessity of providing commercial oral nutritional supplements.

4. The AdSS shall require the Member meet each of the following requirements in order to obtain medically necessary oral nutritional supplements:

    a. The Member is currently underweight with a Body Mass Index (BMI) of less than 18.5, presenting serious health consequences for the Member, or has already demonstrated a medically significant decline in weight within the past three months prior to the assessment;

    b. The Member is not able to consume or eat more than 25% of their nutritional requirements from typical food sources;

    c. The Member has been evaluated and treated for medical

conditions that may cause problems with weight gain and growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems); and

d. The Member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

5. The AdSS shall require the provider submit AMPM Attachment 310-GG (A) from the AdSS' Medical Director or designee's consideration, along with supporting documentation demonstrating the risk posed to the Member in approving the provider's PA request, if it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the Member's overall health.

6. The AdSS shall ensure supporting documentation

accompanies AMPM Attachment 310-GG (A) that demonstrates the Member meets all of the following required criteria:

a. Initial Requests:

i. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the Member by the PCP or specialty provider, or through consultation with a registered dietitian;

ii. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the Member meeting all of the required criteria listed in AMPM Attachment 310-GG (A). The physical assessment shall include the Member's current and past height, weight, and BMI;

iii. Documentation detailing alternatives that were tried

in an effort to boost caloric intake or changes in food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as Member adherence to the prescribed dietary plan and alternatives attempted.

b. Ongoing Requests:

i. Subsequent submissions shall include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request; that includes the Member's overall response to supplemental therapy and justification for continued supplement use. This shall include the Member's tolerance, recent hospitalizations, current height, weight, and BMI;

ii. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the Member from supplemental nutritional feedings should be included, when appropriate;

iii. Members receiving nutritional therapy shall be physically assessed by the Member's PCP, specialty provider, or registered dietitian at least annually; and

iv. Initial and ongoing certificate of medical necessity is considered valid for a period of six months.

D. METABOLIC MEDICAL FOODS

1. The AdSS shall cover metabolic formulas and Medical Foods for Members diagnosed with metabolic conditions that are screened for using the Newborn Screening Panel authorized by the Arizona Department of Health Services.

2. The AdSS shall cover metabolic formulas and medical foods as specified in A.R.S. § 20-2327 and within the following limitations:

   a. The AdSS are responsible for the initial and follow-up consultations by a genetics physician or a metabolic nutritionist;

b. The AdSS are responsible for all medically necessary laboratory tests and other services related to the provision of medical formulas or foods for Members diagnosed with an inherited metabolic disorder;

c. Metabolic formula or modified low protein foods shall be:

i. Processed or formulated to be deficient in the nutrients specific to the Member's metabolic condition;

ii. Meet the Member's distinctive nutritional requirements;

iii. Determined to be essential to sustain the Member's optimal growth within nationally recognized height, weight, BMI and metabolic homeostasis;

iv. Obtained under physician order; and

v. The Member's medical and nutritional status is supervised by the Member's PCP, attending physician or appropriate specialist.

d. Modified low protein foods shall be formulated to contain less than 1 gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein;

e. The AdSS shall ensure the member's medical and nutritional status is supervised by the member's PCP, attending physician or appropriate specialist;

f. Soy formula is covered only for Members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and only until the Member is able to eat solid lactose-free foods;

g. Foods that are available in the grocery store or health food store are not covered as a metabolic food; and

h. Education and training is required regarding proper sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the Member if the Responsible Person elects to prepare the

Member's food.

E. TOTAL PARENTERAL NUTRITION

1. The AdSS shall follow Medicare requirements for the provision of Total Parenteral Nutrition (TPN) services.

2. The AdSS shall cover TPN for Members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

3. The AdSS shall cover TPN when medically necessary, for Members receiving EPSDT.

F. SUPPLEMENTAL INFORMATION

For a listing of metabolic conditions and the Newborn Screening Panel refer to the Arizona Department of Health Services at https://www.azdhs.gov/documents/preparedness/state-laboratory/newborn-screening/providers/az-newborn-screening-panel-of-conditions.pdf?v=20230504.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 16:00 MST)

Anthony Dekker, D.O.

310-HH END OF LIFE CARE AND ADVANCE CARE PLANNING

REVISION DATE: 6/22/2022

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S §§ 36-3231, 36-551; 42 C.F.R. 489.102; AdSS 310-J, 415, 640

PURPOSE

This Policy establishes guidelines for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

DEFINITIONS

1. "Advance Care Planning" is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
    a. Educate the member/responsible person about the member's illness and the health care options that are available to them.
    b. Develop a written plan of care that identifies the member's choices for treatment.
    c. Share the member's wishes with family, friends, and his or her physicians.
2. "Advance Directive" is a document by which a person makes provision for health care decisions in the event that, in the future, he/she

becomes unable to make those decisions.

3. “Curative Care” includes health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.

4. “End-of-Life Care” is a concept of care, for the duration of the member’s life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

5. “Hospice Services” is a program of care and support for terminally ill members who meet the specified medical criteria/requirements.

6. “Practical Support” includes non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to: housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

7. “Qualified Direct Care Worker” is an individual who demonstrates Direct Care Worker (DCW) competencies by passing the required knowledge and skills tests. The DCW Agency is responsible for determining the DCWs competency to provide care utilizing the agency’s policies and procedures, the DCW job description and the supports needs of the members served by

the DCW. In some instances, qualified DCWs may not yet be employed or contracted by a DCW Agency.

8. "Qualified Healthcare Professional" is, for the purposes of Advance Care Planning, a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or Nurse Practitioner (NP).

9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

POLICY

A. END OF LIFE CARE

The AdSS shall provide End of Life (EOL) care that is member-centric, includes Advance Care Planning, and the delivery of appropriate health care services and practical supports in conjunction with Support Coordination.

The goals of EOL care shall focus on providing treatment, comfort, and quality of life for the duration of the member's life. Care management is provided to qualifying members/responsible persons to coordinate with treatment provider(s) to meet the member's individual needs.

EOL care is available to members under the age of 21 in conjunction with curative care and hospice care. EOL care for members aged 21 and older can be provided in conjunction with curative care until the member chooses to receive hospice care.

EOL care strives to ensure members achieve quality of life through the provision of services coordinating between the AdSS care management and Division Support Coordination to determine the services and supports necessary to meet the member's needs, including:

1. Physical and/or behavioral health medical treatment to:
    a. Treat the underlying illness and other comorbidities
    b. Relieve pain
    c. Relieve stress
2. Referrals to community resources for services such as, but not limited to:
    a. Pastoral/counseling services
    b. Legal services
3. Practical supports are non-billable services provided by a family

member, friend or volunteer, who are not paid as Direct Care Workers, to assist or perform functions such as, but not limited to:

a. Housekeeping

b. Personal Care

c. Food preparation

d. Shopping

e. Pet care

f. Non-medical comfort measures

B. ADVANCE CARE PLANNING

Advance Care Planning shall be initiated by the member's qualified healthcare professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. Advance Care Planning shall be an ongoing process for the duration of the member's life.

1. The AdSS shall ensure network providers perform the following as part of the Advance Care Planning/EOL concept of care when treating Division members:

a. Conduct a face-to-face discussion with the member/responsible person.

b. Educate the member/responsible person/ about the member's illness and the health care options that are available to the member to enable them to make educated decisions.

c. Identify the member's healthcare, social, psychological and spiritual needs.

d. Develop a written member centered EOL plan of care that identifies the member's choices for care and treatment, as well as life goals.

e. Share the EOL plan with the care manager and Division Support Coordinator.

f. Share the member's wishes with appropriate designated family, friends, and specialty providers, as appropriate, his or her physicians.

g. Complete Advance Directives.

h. Complete referrals to community resources based on member's needs.

i. Assist the member/responsible person/ in identifying practical supports to meet the member's needs.

2. The AdSS ensures Advanced Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The service may be billed separately during a well or sick visit.

C. ADVANCE DIRECTIVES

Advance Care Planning often results in the creation of an Advance Directive for the member. Members have the right to have information provided to them about the importance of Advance Directives including their rights to establish and rescind Directives at any time.

1. The AdSS shall ensure providers comply with AdSS Medical Manual Policy 640 pertaining to Advance Directives, at a minimum, providers shall comply with the following:

   a. Maintain written policies for adult members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an Advance Directive.

b. Provide written information to adult members regarding the provider's policies concerning Advance Directives, including any conscientious objections.

c. Document in the member's medical record whether or not the adult member has been provided the information, and whether an Advance Directive has been executed.

d. Prevent discrimination against a member because of his or her decision to execute or not execute an Advance Directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive.

e. Provide education to staff on issues concerning Advance Directives including notification to staff who provide services such as home health care and personal care services (e.g. attendant care, respite, personal care) if any Advance Directives are executed by members to whom they are assigned to provide services.

f. Ensure alternative Home and Community Based Services (HCBS) setting staff have immediate access to advance directive documents to provide to first responder requests.

2. All AdSS enrolled adult members, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:

   a. The member's rights, regarding Advance Directives under Arizona State law.

   b. The AdSS's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

   c. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. This statement, at a minimum, shall:

      i. Clarify institution-wide conscientious objections and those of individual physicians,

      ii. Identify state legal authority permitting such objections, and

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

d. A description of the applicable state law and information regarding the implementation of these rights.

e. The member's right to file complaints with ADHS Division of Licensing Services.

3. AdSS providers shall provide a copy of a member's executed Advance Directive or documentation of refusal, to the member's Primary Care Provider (PCP) for inclusion in the member's medical record and provide education to staff on issues concerning Advance Directives.

D. HOSPICE SERVICES

The AdSS shall provide hospice services in accordance with AdSS Medical Manual Policy 310-J.

E. TRAINING

1. The AdSS shall ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

2. The appropriate AdSS staff are educated in the concepts of EOL

care, Advance Care Planning and Advanced Directives.

a. Documentation of the training and attendance shall be submitted to the Division on an annual basis.

F. NETWORK ADEQUACY

The AdSS shall ensure an adequate network of providers who are trained to conduct Advance Care Planning in accordance with AdSS Operations Manual Policy 415.

G. REPORTING REQUIREMENTS TO THE DIVISION

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS to review compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:50 PDT)
Anthony Dekker, D.O.

310-II GENETIC TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-II

PURPOSE

This policy establishes the coverage requirements and limitations of Genetic Testing for the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Genetic Testing" means the sequencing of human Deoxyribonucleic Acid (DNA) obtained from a small sample of body fluid or tissue in order to discover genetic differences, anomalies, or mutations.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. GENETIC TESTING

1. The AdSS shall cover medically necessary Genetic Testing and counseling when the following criteria are met:

a. When the Member:

i. Displays clinical features of a suspected genetic condition;

ii. Is at direct risk of inheriting the genetic condition in question which could be due to:

a) A causative familial variant has been identified in a close family member, or

b) The Member's family history indicates a high risk.

iii. Is being considered for treatment which has significant risk of serious adverse reactions, or is ineffective, in a specific genotype.

b. The results of the Genetic Testing are necessary to:

i. Differentiate between treatment options;

ii. The Member has indicated they will pursue treatment based on the results of the testing; and

iii. An improved clinical outcome is probable as evidenced by:

a) Clinical studies of fair-to-good quality published in peer-reviewed medical literature have established that actions taken as a result of the test will improve clinical outcome for the Member; or

b) Treatment has been demonstrated to be safe and likely to be effective based on the weight of opinions from specialists who provide the service or related services if the condition is rare.

c. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

d. A licensed genetic counselor or the ordering provider has counseled the Member about the medical treatment options prior to the genetic test being conducted.

2. The AdSS shall cover the following medically necessary Genetic Testing and counseling, irrespective of the requirements listed above:
    a. The results of the Genetic Testing will confirm either:
        i. A diagnosis and by so doing avoid further testing that is invasive and has risks of complications; or
        ii. A significant developmental delay in an infant or child and the cause has not been determined through routine testing with one of the following met:
            a) The genetic testing is limited to Chromosomal Microarray (CMA),
            b) Chromosomal testing for Fragile X, or
            c) Any further gene testing meets all other criteria in this policy.
    b. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

c. A licensed genetic counselor or the ordering provider has counseled the Member prior to the genetic test being conducted.

B. LIMITATIONS

1. The AdSS shall not cover Genetic Testing under the following circumstances:
   a. To determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatment of the Member except as described above in A (2)(a);
   b. To determine the likelihood of associated medical conditions occurring in the future;
   c. As a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly;
   d. For purposes of determining current or future reproductive decisions;
   e. For determining eligibility for a clinical trial; or

f. Paying for panels or batteries of tests that include one or more medically necessary tests, along with tests that are not medically necessary, when the medically necessary tests are available individually.

C. PRIOR AUTHORIZATIONS

1. The AdSS shall require that prior authorization requests include documentation regarding how the Genetic Testing is consistent with the Genetic Testing coverage and include:
   a. Recommendations from a licensed genetic counselor or ordering provider;
   b. Clinical findings including family history and any previous test results;
   c. A description of how the genetic test results will differentiate between treatment options for the Member or meet the requirements of section A(2)(a) or A(2)(b);
   d. The rationale for choosing one of these types of genetic testing:
      i. Full gene sequencing,

ii. Deletion or duplication,

iii. Microarray, and

iv. Individual variants.

e. Medical literature citations as applicable.

SUPPLEMENTAL INFORMATION

Pursuant to A.R.S. §36-694, all babies born in Arizona are tested for specific congenital disorders through the Arizona Department of Health Newborn Screening Program. Newborn screening including confirmatory testing is not subject to the requirements of this Policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:15 MST)
Anthony Dekker, D.O.

310-KK BIOMARKER TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-KK

PURPOSE

This policy establishes the coverage requirements of Biomarker Testing for the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention which includes gene mutations or protein expression.
2. "Biomarker Testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, which includes single-analyte tests, multiplex panel tests and whole genome sequencing.

3. "Clinical Utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.
4. "Member" means the same as "Client" as defined in A.R.S. §36-551.

POLICY

A. BIOMARKER TESTING

1. The AdSS shall cover medically necessary non-experimental Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions when the test provides Clinical Utility as demonstrated by the following medical and scientific evidence:

a. Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for a drug that is approved by the FDA;

b. Centers for Medicare and Medicaid Services (CMS) national coverage determinations or Medicare administrative contractor local coverage determinations; or

c. Nationally recognized clinical practice guidelines and consensus statements as outlined in A.R.S. § 20-841.13.

2. The AdSS shall cover Biomarker Testing with the same scope, duration, and frequency as the system otherwise provides to Members pursuant to A.R.S. § 36-2907.03.

3. The AdSS shall ensure that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

4. The AdSS shall require prior authorization for Biomarker Testing.

5. The AdSS shall have a clear and readily available process to accept electronic requests from providers for exceptions to a coverage policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:16 MST)

Anthony Dekker, D.O.

320-B MEMBER PARTICIPATION IN EXPERIMENTAL SERVICES AND CLINICAL TRIALS

EFFECTIVE DATE: May 17, 2023
REFERENCES: AMPM 320-B

PURPOSE

This policy describes the responsibilities related to Experimental Services and Qualifying Clinical Trials. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Experimental Services" means a service which is not generally and widely accepted as a standard of care in the practice of medicine in the United States and is not a safe and effective treatment for the condition for which it is intended or used as specified in A.A.C. R9-22-203.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Qualifying Clinical Trial" means any clinical phase of development that is conducted in relation to the prevention,

detection, or treatment of any serious or life threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg)(2)(A) of the Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by nationally recognized medical research organizations or institutions.

4. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

POLICY

A. PARTICIPATION IN CLINICAL TRIALS

1. The AdSS shall ensure that Members may participate in clinical trials, but shall not reimburse for the Experimental Services.

2. The AdSS shall cover services related to the Qualifying Clinical Trial, including but not limited to:
   a. Routine care,
   b. Screenings,
   c. Laboratory tests,
   d. Imaging services,
   e. Physician services,
   f. Treatment of complications arising from clinical trial participation, or
   g. Other medical services and costs.
3. The AdSS shall not block or attempt to block an Eligible Patient's access to an Individualized Investigational Treatment.

B. COVERAGE DETERMINATION

1. The AdSS shall expedite and complete a determination of coverage for a Member to participate in a Qualifying Clinical Trial within 72 hours regardless of the geographic location or if the provider is in network.

2. The AdSS shall not deny coverage of a routine member's costs based on:
   a. Where the clinical trial is conducted, including out of state; or
   b. Whether the provider treating the Member is outside of the network.
3. The AdSS Chief Medical Officer, Medical Director, or designee shall describes the responsibilities related to Experimental Services and Qualifying Clinical Trials. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).using the following criteria:
   a. The clinical regimen is well-designed, and adequate protection of the Member's welfare is assured;
   b. Provider specification of the clinical trial and any associated service are not provided to prevent, diagnose, monitor, or treat complications resulting from participation in the clinical trial;

c. Verification that full financial liability for the clinical trial is taken by the researcher or the sponsor, and not be charged to, or paid by AHCCCS;

d. The trial provides adequate participant information and assures participant consent;

e. Completion of Attachment A and Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial;

f. Fees, finder's fees, or other payment for referring Members for clinical trials are not received; and

g. The Member's primary care provider has no financial interest in the clinical trial.

4. The AdSS shall submit a Second Level Review to the Division for any Member to participate in Experimental Services or Qualifying Clinical Trial prior to approving or denying services.

5. The AdSS shall ensure Members rights are being protected when approved to participate in a clinical trial.

Signature of Chief Medical Officer: Anthony Dekker (May 10, 2023 11:12 PDT)
Anthony Dekker, D.O.

320-I TELEHEALTH AND TELEMEDICINE

REVISION DATE: 12/21/2022
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 U.S.C. 1396d, A.R.S. § 36-3602, A.R.S. § 36-3605, A.R.S. § 36-3606, A.R.S. § 36-3607, AMPM 310-P, AMPM Policy 431, AMPM 670, AMPM 820, ACOM 436.

PURPOSE

This policy describes covered Telehealth and Telemedicine services for Division of Developmental Disability (DDD) members who are eligible for Arizona Long Term Care System (ALTCS). This policy applies to DDD's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Asynchronous"" means the transfer of data from one site to another through the use of a camera or similar device that records an image that is sent via Telecommunication to another site for consultation. Asynchronous applications would not be considered Telemedicine but may be utilized to deliver services. Asynchronous services are rendered after the initial collection of

data from the member and are provided without real-time interaction with the member.

2. "Consulting Provider" means any Arizona Health Care Cost Containment System (AHCCCS)-registered provider who is not located at the Originating Site who provides an expert opinion to assist in the diagnosis or treatment of a member.

3. "Distant Site" means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via Telecommunications system."

4. "Originating Site" means the location of the patient at the time the service being furnished via a Telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service. The Place of Service (POS) on the service claim is the Originating Site.

5. "Synchronous" means the real time two-way interaction between the member and provider, using interactive audio and video.

6. "Telecommunications Technology" (which includes asynchronous applications) means the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records an image which is then sent via Telecommunication to another site for consultation. Services delivered using Telecommunications Technology, but not requiring the member to be present during their implementation, are not considered Telemedicine.

7. "Teledentistry" means the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by a AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

8. "Telehealth" means the use of Telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distances.

9. "Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the Originating and Distant Sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

POLICY

A. TELEHEALTH

1. The AdSS shall cover medically necessary, non-experimental, and cost-effective services delivered via Telehealth for Division covered services.

2. The AdSS shall cover services delivered via Telehealth in rural and urban regions; there are no geographic restrictions for Telehealth.

3. The AdSS shall not limit or deny the coverage of services provided through Telehealth and shall apply the same limits or exclusions on a service provided through Telehealth that are applicable to an in-person encounter for the same service,

except for services for which the weight of evidence determines the service not to be appropriate to be provided through Telehealth, based on:

a. Practice guidelines,

b. Peer-reviewed clinical publications or research, or

c. Recommendations by the telehealth advisory committee on telehealth best practices.

4. The AdSS shall not permit services delivered via Telehealth to replace member or provider choice for healthcare delivery modality.

5. The AdSS shall ensure a provider makes a good faith effort in determining both of the following:

a. Whether a service should be provided through Telehealth instead of in-person. The provider shall use clinical judgment in considering whether the nature of the services necessitates physical interventions and close observation and the circumstances of the member, including:

i. Diagnosis,

ii. Symptoms,

iii. History,

iv. Age,

v. Physical location, and

vi. Access to Telehealth.

b. The communication medium of Telehealth and whenever reasonably practicable, the Telehealth communication medium that allows the provider to most effectively assess, diagnose and treat the member. Factors the provider may consider in determining the communication medium include:

i. The member's lack of access to or inability to use technology, or

ii. Limits in Telecommunication infrastructure necessary to support interactive Telehealth encounters.

6. The AdSS may allow a provider who is not licensed within the State of Arizona to provide Telehealth services to a member located in the State if the following conditions are met:

a. The provider is an AHCCCS-registered provider, and

b. The provider complies with all requirements listed within A.R.S. § 36-3606.

B. TELEMEDICINE SERVICES

1. The AdSS shall cover Telemedicine services, including health care delivery, diagnosis, consultation, treatment, and the transfer of medical data through real-time synchronous interactive audio and video communications that occur in the physical presence of the member.
2. The AdSS shall reimburse providers at the same level of payment for equivalent services as identified by Healthcare Common Procedure Coding System (HCPCS) whether provided via Telemedicine or in-person.

C. ASYNCHRONOUS SERVICES

1. The AdSS shall provide reimbursement for consultation limited to clinically appropriate services that are provided without real-time interaction. Reimbursement is limited to the following services:

a. Dermatology,

b. Radiology,

c. Ophthalmology,

d. Pathology,

e. Neurology,

f. Cardiology,

g. Behavioral Health,

h. Infectious Diseases, or

i. Allergy/Immunology.

D. E-CONSULT SERVICES

1. The AdSS shall cover medically necessary e-consult visits, to aid in the coordination of care between a Primary Care Provider (PCP) and a specialist, and to improve timely access to specialty providers.

E. REMOTE PATIENT MONITORING SERVICES

1. The AdSS shall cover both synchronous and asynchronous remote patient monitoring.

2. The AdSS shall limit coverage of equipment and/or supplies for remote patient monitoring to when:

   a. The service being provided is an AHCCCS covered service eligible for remote monitoring, and

   b. The equipment and/or supplies are AHCCCS covered items.

F. AUDIO-ONLY SERVICES

1. The AdSS shall cover audio-only services if a Telemedicine encounter is not reasonably available due to the member's functional status, the member's lack of technology or Telecommunications infrastructure limits, as determined by the provider.

2. The AdSS shall reimburse providers at the same level of payment for equivalent in-person mental health and substance use disorder services, as identified by HCPCS, if provided through Telehealth using an audio-only format.

G. TELEDENTISTRY SERVICES

1. The AdSS shall cover Teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider.

2. The AdSS shall cover Teledentistry including the provision of preventative and other approved therapeutic services by the AHCCCS-registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

3. The AdSS shall not use Teledentistry to replace the dental examination by the dentist. Limited exams may be billed through the use of Teledentistry. Periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

H. CONDITIONS AND LIMITATIONS

1. The AdSS shall ensure all Telehealth reimbursable services are provided by an AHCCCS-registered provider within their scope of practice.

1. The AdSS shall cover Non-Emergency Transportation (NEMT) to and from the Originating Site where applicable.

2. The AdSS shall ensure services provided through Telehealth or resulting from a Telehealth encounter are subject to all applicable statutes and rules that govern prescribing, dispensing and administering prescription medications and devices.

3. The AdSS shall ensure informed consent standards for Telehealth services adhere to all applicable statutes and policies governing informed consent.

4. The AdSS shall ensure privacy and confidentiality standards for Telehealth services adhere to all applicable statutes and policies governing healthcare services, including the Health Insurance Portability and Accountability Act (HIPAA).

5. The AdSS shall not place POS restrictions for a Distant Site.

6. The AdSS may qualify Telehealth as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC) visit, if all other applicable conditions in this Policy are met.

I. SUPPLEMENTAL INFORMATION

1. The AHCCCS Telehealth code set defines which codes are billable, the applicable modifier(s) and place of service that providers must use when billing for the following services when provided through remote patient monitoring:
   a. Telemedicine services,
   b. Asynchronous services,
   c. E-consult services,
   d. Remote patient monitoring services, and
   e. Audio-only services.

2. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of Telemedicine, they are often considered under the broad umbrella of Telehealth services. Even though such technologies are not considered Telemedicine, they may nevertheless be covered and reimbursed as part of a

Medicaid coverable service, such as laboratory service, x-ray service or physician services.

Signature of Chief Medical Officer: Anthony Dekker (Dec 19, 2022 08:06 MST)

Anthony Dekker, D.O.

320-M MEDICAL MARIJUANA AND CBD OIL PRODUCTS

REVISED DATE: 7/13/2022
EFFECTIVE DATE: January 15, 2020
REFERENCES: 9 A.A.C. 22, Article 2, 42 CFR 440.120, AMPM 320-M Medical Marijuana

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division contracts with Administrative Services Subcontractors (AdSS) and delegates the responsibility of implementation of this policy. This policy establishes requirements for the coverage and use of medical marijuana and all cannabidiol (CBD) products (regardless of plant derivation).

DEFINITIONS

1. "AHCCCS Registered Provider" - means a contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS-covered services.

2. "Medical Marijuana" means products that are a cannabis product requiring a medical marijuana card and are sold in a Marijuana

Dispensary or a CBD Oil store.

POLICY

A. Medical Marijuana and CBD Products

The Division and AdSS cover medically necessary federally or state reimbursable medications prescribed by a physician, physician assistant, nurse practitioner, dentist or other AHCCCS approved practitioner and dispensed by a licensed AHCCCS registered pharmacy, as defined in 9 A.A.C. 22, Article 2. Under 42 CFR 440.120 Medical Marijuana or CBD Oil products do not qualify as federally or state reimbursable medications.

The Division and AdSS do not cover medical marijuana or CBD Oil. AdSS shall not provide reimbursement for an office visit, these products or any other services that are primarily for the purpose of determining if a member would benefit from medical marijuana. The Division recognizes that AHCCCS registered providers operating within the scope of their license may recommend the use of medical marijuana or CBD Oil although it is not a covered benefit.

Under no circumstance shall any owner, director, principal, agent, employee, subcontractor, volunteer, or staff of the AdSS' service providers administer or store medical marijuana or CBD Oil products (regardless of the plant) for Division members.

Examples of medical marijuana products would include marijuana plants, pre-rolled marijuana cigarettes, marijuana edibles, marijuana vaping products etc.

B. FDA Approved Cannabidiol Products

This policy does not apply to the prescribing or administering of FDA approved medications that may include cannabidiol or its components. Under Federal Law, there are currently prescription medications commercially available that contain cannabidiol ingredients. Medications such as Epidiolex™ (cannabidiol) and Marinol™ (dronabinol), are allowed because they are FDA approved products, requiring a prescription and dispensed by an AHCCCS registered pharmacy.

Signature of Chief Medical Officer: Anthony Dekker (Jul 6, 2022 12:05 PDT)
Anthony Dekker, D.O.

320-O BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

REVISION DATE: March 3, 2021

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 32-2061, A.R.S. § 32-2091, A.R.S. § 32-3251 et seq., A.R.S. § 36-501; A.A.C. R4-6-101, A.A.C. R9-10, A.A.C R9-21

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy describes the provisions for behavioral health assessment and treatment/service planning for Division members enrolled with a DDD subcontracted health plan.

DEFINITIONS

Behavioral Health Assessment is the ongoing collection and analysis of an individual's medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Behavioral Health Professional (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091,
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:
    a. A psychiatric-mental health nursing certification, or

b. One year of experience providing behavioral health services.

Behavioral Health Technician (BHT) as specified in A.A.C. R9-10-101, an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

2. Are provided with clinical oversight by a behavioral health professional.

Designated Representative for purposes of this Policy, an individual chosen by a member who carries a serious mental illness designation and has been identified by AHCCCS Special Assistance. The Designated Representative protects the interests of the member during service planning, inpatient treatment discharge planning, and the SMI grievance, investigation or appeal process.

Health Care Decision Maker is an individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an un-emancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

Health Home is a provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center, or an Integrated Care Provider. Members may or may not be formally assigned to a Health Home.

Service Plan is a complete written description of all covered health services and other informal supports which includes individualized goals, peer and recovery support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Treatment Plan is a written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multispecialty, interdisciplinary team.

A. Overview

1. The model for behavioral health assessment, treatment/service planning and service delivery shall be strength-based, member-centered, family-friendly, based on voice and choice, culturally and linguistically appropriate, and clinically supervised.

2. The model incorporates the concept of a "team," established for each member receiving behavioral health services.

3. The model is based on four equally important components:

   a. Input from the member, or when applicable the health care decision maker, and designated representative regarding the member's needs, strengths and preferences;

   b. Input from other individuals involved in the member's care who have important relationships with the member;

   c. Development of a therapeutic alliance between the member, or when applicable the health care decision maker, and the designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality; and

   d. Clinical expertise/qualifications of individuals conducting the assessment, treatment/service planning, and service delivery.

4. For children, this team is the Child and Family Team (CFT). For adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

   a. Ongoing engagement of the member, or when applicable the health care decision maker, and the designated representative, family, assigned Support Coordinator, and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment. The member's Support Coordinator must participate in all CFT and ART meetings.

   b. An assessment process that is conducted to:

      i. Elicit information on the strengths and needs of the member and member's family,

      ii. Identify the need for further or specialty evaluations, and

      iii. Support the development and updating of the treatment/service plan which effectively meets the member and family needs and results in improved health outcomes.

   c. Continuous evaluation of treatment effectiveness through the CFT or ART process, the ongoing assessment of the member, and input from the member, or when applicable the health care decision maker, and the designated representative and Support Coordinator, resulting in modification to the treatment plan, as necessary.

d. Provision of all covered services as identified on the treatment/ service plan(s), including assistance in accessing community resources as appropriate.

e. For children, services are provided consistent with the Arizona Vision - 12 Principles as specified in the AMPM Policy 100 and the AHCCCS Child and Family Team Behavioral Health System Practice Tool. For adults, services are provided consistent with the Adult Service Delivery System - 9 Guiding Principles.

f. Ongoing collaboration with other people and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g. primary care providers, specialty service providers, school, child welfare, DDD, justice system and others). This shall include sharing of clinical information as appropriate.

g. Ensure continuity of care by assisting members who are transitioning to a different treatment program, changing behavioral health providers, and/or transferring to another service delivery system (e.g. out of state). For more details see AdSS Operations Policy 402 and Medical Policy 520.

5. At least one Peer Recovery Support Specialist may be assigned to each ART to provide covered services, when appropriate, and provide access to peer support services for individuals with Substance Use Disorders, including Opioid Use Disorders, for purposes of navigating members to Medication Assisted Treatment (MAT) and increasing participation and retention in MAT treatment and recovery supports.

6. The AdSS shall require subcontractors and providers to make available and offer the option of having a Family Support Specialist for each CFT to provide covered services when appropriate.

B. Assessment and Service Planning

1. General Requirements for behavioral health assessments and treatment/service planning shall comply with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, as applicable. AMPM 320-O, Attachment A, shall be utilized by the member, or when applicable the health care decision maker, and the designated representative to indicate agreement or disagreement with Service Plan and awareness of rights to appeal process if not in agreement with Service Plan.

2. Assessments, Service and Treatment Plans shall be completed by BHPs or BHTs under the clinical oversight of a BHP.

3. Behavioral health providers outside of the Health Home may complete Assessment, Service and Treatment Planning to support timely access

to medically necessary behavioral health services, as allowed under licensure (A.A.C. R9, et. seq.),

a. Should a specialty provider complete any type of behavioral health assessment, the specialty provider shall communicate with the Health Home regarding assessment findings. In situations where a specific assessment is duplicated and findings are discrepant, specialty provider and Health Home BHP or BHT shall discuss the differences and clinical implications for treatment needs. Differences shall be addressed within the CFT with participation from both the Health Home and specialty provider,

b. Behavioral Health Providers shall supply completed Assessment and Service and Treatment Plan documentation to the Health Home for inclusion in the member's medical record,

c. The assessment and service planning shall be implemented to align, as much as possible, with the Division's assessment and Service Plan, and

d. For those Division members that have also been determined SMI, service planning and treatment shall be implemented to align with all requirements for SMI members under Division, AHCCCS and State of Arizona policy and rules, including AdSS Medical Policies 310-B, 320-P, 320-Q and 320-R; AdSS Operations Policies 444 and 446.

4. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) must be met.

5. At a minimum, the member, or when applicable the health care decision maker, and the designated representative and a BHP shall be included in the assessment process and development of the treatment/service plan.

6. The assessment and treatment/service plan must be included in the clinical record in accordance with AdSS Medical Policy 940.

7. The treatment/service plan shall be based on the current assessment and identify the specific services and supports to be provided, as specified in AdSS Policy 310-B. The Treatment Plan shall be developed based on specific treatment needs (e.g. out-of-home services, specialized behavioral health therapeutic treatment for substance use or other specific treatment needs). Services within the Treatment/Service Plan are based on the range of services covered under AHCCCS policies.

8. The behavioral health provider shall document whether the member, or when applicable the health care decision maker, and the designated representative agrees with the treatment/service plan by either a

written or electronic signature on the Service or Treatment Plan.

9. The member, or when applicable the health care decision maker, and the designated representative shall be provided with a copy of his/her service plan within seven calendar days of completion of the service plan and/or upon request.

10. SMI Determination shall be completed for members who request an SMI determination in accordance with AdSS Medical Policy 320-P.

11. For members determined SMI:

    a. Assessment and treatment/service planning must be conducted in accordance with A.A.C. R9-21-301 et seq. and A.A.C. R9-21- 401 et seq.

    b. Special Assistance assessment shall be completed in accordance with AdSS Medical Policy 320-R.

    c. The completed treatment/service plan must be signed by the member, or when applicable the health care decision maker and the designated representative, in accordance with A.A.C. R9-21-308.

    d. For appeal requirements, see A.A.C. R9-21-401 et seq. and AdSS Operations Policy 444.

12. The Health Home is responsible for maintaining the comprehensive assessment and conducting periodic assessment updates to meet the changing behavioral health needs for members who continue to receive behavioral health services,

13. Behavioral Health Assessments, Treatment and Service Plans shall be updated at a minimum of once annually or more often as needed, based on clinical necessity and/or upon significant life events including but not limited to:

    a. Moving,

    b. Death of a friend or family member,

    c. Change in family structure (e.g., divorce, incarceration),

    d. Hospitalization,

    e. Major illness of member or family member,

    f. Incarceration, and

    g. Any event which may cause a disruption of normal life activities.

14. The Health Home is responsible for maintaining the treatment/service plan and conducting periodic treatment/service plan updates to meet the changing behavioral health needs for members who continue to receive behavioral health services,

15. The Health Home shall coordinate with any entity involved in the member's Behavioral Health Assessment and Treatment and Service Planning (Refer to AdSS Medical Policy 541), and

16. Special Circumstances:

    a. Children Age 6 through 17 - An age-appropriate assessment shall be completed by the Health Home during the initial assessment and updated at least every six months, and this information shall be provided to the TRBHA or Division,

    b. Children Age 6 through 17 - Strength, Needs and Culture Discovery Document shall be completed, as deemed appropriate, by the Health Home, and this information shall be provided to the TRBHA or Division, and

    c. Children Age 11 through 17 - Standardized substance use screen and referral for further evaluation when screened positive shall be completed by the Health Home, and this information shall be provided to the TRBHA or Division.

C. Crisis and Safety Planning

1. General Purpose of a Crisis and Safety Plan

   A Crisis and Safety Plan provides a written method for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis. The Crisis and Safety Plan shall be developed in accordance with the Vision and Guiding Principles of the Children's' System of Care and the Nine Guiding Principles of the Adult System of Care as specified in AMPM Policy 100. Crisis and Safety plans shall be trauma informed, with a focus on safety and harm reduction.

   The development of a Crisis and Safety Plan shall be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior plan if applicable. It shall be considered, when clinically indicated. Clinical indicators may include, but are not limited needs identified in members Treatment, Service, or Behavior plan in addition to any one or a combination of the following:

   a. Previous psychiatric hospitalizations,

   b. Out-of-home placements,

   c. HCBS settings,

d. Nursing Facilities,

e. Group Home settings,

f. Special Health Care Needs,

g. Court-Ordered Treatment,

h. History of DTS/DTO,

i. Individuals with an SMI designation, and

j. Individuals identified as high risk/high needs.

Crisis and Safety Plans shall be updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the Crisis and Safety Plan shall be distributed to the team members that assisted with development of the Crisis and Safety Plan.

A Crisis and Safety Plan does not replace or supplant a Mental Health Power of Attorney or behavior plan, but rather serves as a compliment to these existing documents.

2. Essential Elements

A Crisis and Safety Plan shall establish goals to prevent or ameliorate the effects of a crisis and shall specifically address:

a. Techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the CFT or ART,

b. Identification of realistic interventions that are most helpful or not helpful to the individual and his/her family members or support system,

c. Reduction of symptoms,

d. Guiding the support system toward ways to be most helpful,

e. Any physical limitations, comorbid conditions, or unique needs of the member (e.g., involvement with DCS or Special Assistance),

f. Adherence to court-ordered treatment (if applicable),

g. Necessary resources to reduce the chance for a crisis or minimize the effects of an active crisis for the member. This may include but is not limited to:

i. Clinical (support staff/professionals), medication, family, friends, parent, guardian, environmental,

ii. Notification to and/or coordination with others, and

iii. Assistance with and/or management of concerns outside of crisis (e.g., animal care, children, family members, roommates, housing, financials, medical needs, school, work).

320-P SERIOUS EMOTIONAL DISTURBANCE AND SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATIONS

REVISION DATE: 2/7/2024, 7/14/2021
REVIEW DATE: 9/19/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. 36-550, A.A.C. R9-21-101(B), Division Medical Policy 320-P

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and establishes requirements for eligibility determinations for individuals with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). The Division contracts with the AdSS and delegates the responsibilities of implementing this policy. The Division provides oversight and monitoring of delegated duties.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday or Friday, excluding State and Federal Holidays.

2. "Designated Representative" means an individual parent, guardian, relative, advocate, friend, or other individual, designated orally or in

writing by a Member or Responsible Person who, upon the request of the Member, assists the Member in protecting the Member's rights and voicing the Member's service needs.

3. "Determining Entity" means an entity designated by AHCCCS and authorized to make SED and SMI eligibility determinations.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Removal of Serious Emotional Disturbance Designation" means the process that results in the removal of the SED behavioral health category from the individual's most recent, active enrollment segment.

6. "Removal of Serious Mental Illness Designation" means the process that results in a modification to a Member's medical record by changing the behavioral health category designation from SMI to General Mental Health.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

8. "Serious Emotional Disturbance" means a designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the individual's role or functioning in family, school, or community activities.

9. "Serious Mental Illness" means a designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.

10. "Serious Emotional Disturbance or Serious Mental Illness Eligibility Determination" means a process used to determine whether an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SED or SMI services.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall ensure all Members from birth to 18 years of age are evaluated for SED eligibility by a qualified clinician and

referred to the Determining Entity if the Responsible Person or Designated Representative makes such a request.

2. The AdSS shall ensure all Members ages 17.5 or older are evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and are referred to the Determining Entity if:
   a. The Responsible Person or Designated Representative makes such a request,
   b. An Arizona Court issues an order instructing a Member to undergo an SMI evaluation,
   c. It is clinically indicated by the presence of a qualifying diagnosis, or
   d. There is reason to believe that the assessment may indicate the presence of a qualifying diagnosis and functional limitation(s), and
   e. The actual SMI eligibility category will not become effective until a member turns 18 years of age.
3. The AdSS shall ensure the SED and SMI eligibility evaluation records contain all documentation considered during the review,

including current and historical treatment records.

4. The AdSS shall develop and make available to providers any requirements or guidance on SED and SMI eligibility evaluation record location and or maintenance.

5. The AdSS shall computate time as follows:
   a. Day zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment;
   b. Day one: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the Determining Entity as soon as practicable, but no later than 11:59 pm on day one;
   c. Day three: The third business day after the initial assessment is completed. The Determining Entity shall have at least two business days to complete the final SED or SMI determination, but the final SED or SMI determination must be completed no later than day three; and
   d. Determination due date: Day three, three business days after day zero, excluding weekends and holidays, and is

the date that the determination decision must be rendered. This date may be amended if an extension is approved in accordance with this policy.

B. PROCESS FOR COMPLETION OF INITIAL SED OR SMI ASSESSMENT

1. The AdSS shall require behavioral health providers, upon receipt of a referral or identification of the need for an SED or SMI Eligibility Determination, to schedule an assessment with the Member and a qualified clinician, if one has not been completed within the past six months, within seven business days of receipt of the referral or request, or as expeditiously as the Member's health condition requires.

2. For urgent eligibility determination referrals for members admitted to a hospital for psychiatric reasons, the AdSS shall allow the hospital to complete the assessment if it meets the criteria needed to render a decision.

3. The AdSS shall ensure that the qualified clinicians complete the following during the assessment meeting with the Member:

   a. Make a clinical judgment as to whether the Member is

competent to participate in the assessment;

b. Obtain written consent to conduct the assessment from the Member or Responsible Person unless the Member is under court order to undergo an evaluation as part of court-ordered treatment proceedings;

c. Provide the Member or Responsible Person with the information required in A.A.C. R9-21-301(D)(2), a Member rights brochure, and the Member's notice of right to appeal required by A.A.C. R9-21-401(B);

d. Obtain authorization for the release of information, if applicable, for any documentation that would assist in the determination of the Member's eligibility for SED or SMI designation;

e. Conduct an assessment that is an accurate representation of the Member's current level of functioning if one has not been completed within the past six months;

f. Complete the SED or SMI determination packet on the SMI Provider Submission Portal; and

g. Upon completion, submit all information to the Determining Entity within one business day.

C. CRITERIA FOR SED ELIGIBILITY

1. The AdSS shall ensure the final determination of SED includes both a qualifying SED diagnosis and functional impairment because of the qualifying SED diagnosis.

2. The AdSS shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. The AdSS shall ensure the functional criteria for SED, due to a qualifying SED diagnosis, includes dysfunction in at least one of the following four domains for most of the past six months or for most of the past three months with an expected continued duration of at least three months:

    a. Seriously disruptive to family or community:

        i. Pervasively or imminently dangerous to self or others' bodily safety;

        ii. Regularly engages in assaultive behavior;

        iii. Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior;

        iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education or personal relationships.

b. Dysfunction in role performance:

i. Frequently disruptive or in trouble at home or at school;

ii. Frequently suspended or expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised school setting;

v. Performance significantly below expectation for cognitive or developmental level; or

vi. Unable to attend school or meet other developmentally appropriate responsibilities.

c. Child and Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 4, 5, or 6.

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing, and remitting course;

ii. Comorbidities including developmental or intellectual disability, substance use disorder, or personality disorder;

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors; or

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, or care is complicated and requires multiple providers.

4. The AdSS shall not allow the following reasons alone to be sufficient for denial of SED eligibility:

   a. An inability to obtain existing records or information; or

   b. Lack of a face-to-face psychiatric or psychological evaluation.

D. CRITERIA FOR SMI ELIGIBILITY

1. The AdSS shall ensure the final determination of SMI includes both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

2. The AdSS shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. The AdSS shall ensure the functional criteria for SMI status, due to a qualifying SMI diagnosis, includes dysfunction in at least one of the following four domains for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

    a. Inability to live in an independent or family setting without supervision:

        i. Neglect or disruption of ability to attend to basic needs;

        ii. Needs assistance in caring for self;

        iii. Unable to care for self in a safe or sanitary manner;

        iv. Housing, food and clothing is provided or arranged for by others;

        v. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care;

        vi. Unwilling to seek prenatal care or care for serious medical or dental conditions;

vii. Refuses treatment for life threatening illnesses because of behavioral health disorder; or

viii. A risk of serious harm to self or others.

b. Seriously disruptive to family or community:

i. Pervasively or imminently dangerous to self or others' bodily safety;

ii. Regularly engages in assaultive behavior;

iii. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior;

iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education, livelihood, career, or personal relationships.

c. Dysfunction in role performance:

i. Frequently disruptive or in trouble at work or at school;

ii. Frequently terminated from work or suspended or expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised work or school setting;

v. Performance significantly below expectation for cognitive/developmental level; or

vi. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Comorbidities including developmental and intellectual disability, substance use and personality disorders;

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors;

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of

current compliance only, court-committed, care is complicated and requires multiple providers.

4. The AdSS shall not allow the following reasons alone to be sufficient for denial of SMI eligibility:
   a. An inability to obtain existing records or information; or
   b. Lack of a face-to-face psychiatric or psychological evaluation.

E. MEMBERS WITH CO-OCCURRING SUBSTANCE USE

1. The AdSS shall ensure, for purposes of SED or SMI eligibility determination, presumption of functional impairment is as follows for Members with co-occurring substance use:
   a. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder) functional impairment is presumed to be due to the qualifying mental health diagnosis.

b. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis unless:

i. The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or

ii. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the Member is actively using substances or experiencing symptoms of withdrawal from substances.

iii. In order to make such determinations, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability, and establish that the symptoms and resulting disability were no longer present after the 30- or 60-day period and no

longer required mental health treatment to prevent recurrence of symptoms.

c. A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:

   i. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and

   ii. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.

d. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.

e. For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 days or less should be considered presumptive evidence of a persistent psychotic disorder for SED or SMI eligibility purposes.

f. For Members who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances or do not experience consecutive days of

abstinence, this is not a disqualifier to initiate the SED or SMI eligibility and determination process. Some Members will not meet the 30-day period of abstinence. This does not preclude them from the SED or SMI eligibility assessment and determination process.

F. PROCESS FOR COMPLETION OF FINAL SED OR SMI ELIGIBILITY DETERMINATION

1. The AdSS shall develop policies and procedures that describe the providers' requirements for submitting the evaluation packet and providing additional clinical information for the Determining Entity to make the final SED or SMI eligibility determination.

2. The AdSS shall ensure the evaluating agency responds to the Determining Entity within three business days of a request for additional information to make a final SED or SMI eligibility determination.

G. ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The AdSS shall allow an extension of up to 20 calendar days to initiate or complete the SED or SMI eligibility determination if the Responsible Person agrees to the extension and:

a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;

b. The Member fails to keep an appointment for assessment, evaluation, or any other necessary meeting;

c. The Member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;

d. The Member or Designated Representative requests an extension of time;

e. Additional documentation has been requested but not received; or

f. There is insufficient functional or diagnostic information to determine SED or SMI eligibility within the required time periods.

2. The AdSS shall ensure "insufficient diagnostic information" means that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SED or SMI, and an additional piece of existing historical information or a face-to-face psychiatric

evaluation is likely to support one diagnosis more than the other(s).

H. RE-ENROLLMENT OR TRANSFER

1. The AdSS shall adhere to the following:
    a. If a Member's status is SED or SMI at disenrollment, while incarcerated, or transition to another health plan, the Member's status shall continue as SED or SMI.
    b. A Member shall retain their SED or SMI status unless the Member's enrollment is active and a determination is made by a Determining Entity that the Member no longer meets the criteria.

I. REMOVAL OF SED OR SMI DESIGNATION

1. The AdSS shall indicate in policies and procedures made available to providers, the process for reviewing an SED or SMI designation, including:
    a. A review of the eligibility determination may not be requested within the first six months from the date a Member has been designated as SED or SMI eligible.

b. A review of the Member's SED or SMI designation from the Determining Entity may be requested:

   i. As part of an instituted, periodic review of all Members designated to have an SED or SMI;

   ii. When there has been a clinical assessment that supports the Member no longer meets the functional and or diagnostic criteria; or

   iii. As requested by a Member who has been determined to meet SED or SMI eligibility criteria, or their Responsible Person or Designated Representative.

c. Based on review of the request and clinical data provided, removal of the SED or SMI behavioral health category will occur if:

   i. The individual is an enrolled member and has not received any behavioral health service within the past six months; or

   ii. The Member is determined to no longer meet the diagnostic and or functional requirements for SED or SMI designation.

2. The AdSS shall ensure services are continued in the event of a timely filed appeal, and that services are appropriately transitioned.

SUPPLEMENTAL INFORMATION

The information contained in Sections J through M of this policy are AHCCCS requirements for the Determining Entity authorized by AHCCCS to make the final SED and SMI designation determinations.

J. DETERMINING ENTITY RESPONSIBILITY FOR COMPLETION OF FINAL ELIGIBILITY DETERMINATION

1. A licensed psychiatrist, psychologist or nurse practitioner designated by the Determining Entity will make a final determination as to whether the Member meets the eligibility requirements for SED or SMI status based on:
   a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician; and
   b. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

2. The following shall occur if the designated reviewing psychiatrist,

psychologist or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician that cannot be resolved by oral or written communication:

a. Disagreement regarding diagnosis: Determination that the Member does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement must be documented in the Member's comprehensive clinical record.

b. Disagreement regarding functional impairment: Determination that the Member does not meet eligibility requirements must be documented by the psychiatrist, psychologist or nurse practitioner in the Member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

3. If there is sufficient information to determine SED or SMI eligibility, the Member shall be provided written notice of the eligibility determination within three business days of the initial meeting with the qualified clinician.

K. DETERMINING ENTITY RESPONSIBILITY DUE TO ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The Determining Entity shall:
   a. Document the reasons for the delay in the Member's eligibility determination record when there is an administrative or other emergency that will delay the determination of an SED or SMI status, and
   b. Not use the delay as a waiting period before determining an SED or SMI status or as a reason for determining that the Member does not meet the criteria for SED or SMI eligibility (because the determination was not made within the time standards).

2. In situations in which the extension is due to insufficient information:
   a. The Determining Entity shall request and obtain the

additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations,

b. The designated reviewing psychiatrist, psychologist or nurse practitioner must communicate with the Member's current treating clinician, if any, prior to the determination of an SED or SMI, if there is insufficient information to determine the Member's level of functioning, and

c. Eligibility shall be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

3. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence/reduction from substance use in order to establish a qualifying mental health diagnosis, the Member shall be notified by the Determining Entity that the determination may, with the agreement of the Member, be extended for up to 60 calendar days for an extended evaluation period. This is a 60-day period of abstinence or reduced use

from drug and/or alcohol use in order to help the reviewing psychologist make an informed decision regarding SED or SMI eligibility.

4. This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303; however, the Member does not need to reapply. Alternatively, the determination process may be suspended, and a new application initiated upon receipt of necessary information.

5. If the Member refuses to grant an extension, SED or SMI eligibility shall be determined based on the available information.

6. If SED or SMI eligibility is denied, the Member will be notified of their appeal rights and the option to reapply in accordance with this policy.

L. DETERMINING ENTITY RESPONSIBILITY FOR NOTIFICATION OF SED OR SMI ELIGIBILITY DETERMINATION

1. If the Member is determined to qualify for an SED or SMI designation, this shall be reported to the Member or Responsible Person by the Determining Entity, in writing, including notice of

the Member's right to appeal the decision on the form approved by AHCCCS.

2. If the eligibility determination results in a determination that the Member does not qualify for an SED or SMI designation, the Determining Entity shall provide written notice of the decision and include:
   a. The reason for denial of SED or SMI eligibility,
   b. The right to appeal, and
   c. The statement that Title XIX/XXI eligible individuals will continue to receive needed Title XIX/XXI covered services. In such cases, the Member's behavioral health category assignment shall be assigned based on criteria in the AHCCCS Technical Interface Guidelines

M. DETERMINING ENTITY RESPONSIBILITY FOR REMOVAL OF SED OR SMI DESIGNATION

1. Upon removal of an SED or SMI designation, the Determining Entity is responsible for the following:
   a. Inform the Member of changes that may occur as a result of the designation removal.

b. Provide written notice of the determination and the Member's right to appeal within 30 calendar days from the date of the written notice of determination is issued.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 15:43 MST)

Anthony Dekker, D.O.

320-Q GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-514.05(C), A.R.S. § 15-104, A.R.S. § 36-501 et seq, A.R.S. § 36-2272; A.A.C. R9-21-206.01(c); AMPM Policy 310-V; AMPM 310-V, Attachment A; AMPM Exhibit 320-Q, Attachments A and B

This policy applies to the Division's Administrative Services Subcontractors (AdSS). Each member of the Division of Developmental Disabilities (Division) has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services, be made aware of the service options and alternatives available to them, and to be aware of the specific risks and benefits associated with these services.

Definitions

General Consent - a one-time agreement to receive certain services, including but not limited to behavioral health services, that is usually obtained from a member during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from the member/ responsible person.

Informed Consent - permission granted in the knowledge of the possible consequences; typically consent that is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits. Informed consent is required to be obtained from a member/responsible person prior to the provision of the following services and procedures:

A. Complementary and Alternative Medicine (CAM)

B. Psychotropic medications

C. Electro-Convulsive Therapy (ECT)

D. Use of telemedicine

E. Application for a voluntary evaluation

F. Research

G. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness)

H. Procedures or services with known substantial risks or side effects.

Overview

The Division and AHCCCS recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in A.A.C. R9-21-206.01(c), must present the facts necessary for a

member/responsible person to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the member/responsible person agrees or does not agree to the specific treatment, and the member's/responsible person's signature when required, must be included in the comprehensive clinical record.

In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

General Requirements

A. Any member, aged 18 years and older, in need of behavioral health services, must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.

B. For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. § 8-514.05[C]) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

C. Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

D. Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

E. Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. § 36-501 et seq.

F. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per Policy 940 of this Policy Manual.

G. The Administrative Services Subcontractor (AdSS) must develop and make available to providers policies and procedures that include any additional information or forms.

H. A foster parent, group home staff, foster home staff, relative, or other person or

agency in whose care a child is currently placed may give consent for:

1. Evaluation and treatment for emergency conditions that are not life threatening, and

2. Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. § 8-514.05[C]).

I. To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS), whomever is available to do so immediately upon request (A.R.S. § 8-514.05[C]).

J. Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services for which foster or kinship caregivers can consent include:

1. Assessment and service planning

2. Counseling and therapy

3. Rehabilitation services

4. Medical Services

5. Psychiatric evaluation

6. Psychotropic medication

7. Laboratory services

8. Support Services

9. Case Management

10. Personal Care Services

11. Family Support

12. Peer Support

13. Respite

14. Sign Language or Oral Interpretive Services

15. Transportation

16. Crisis Intervention Services

17. Behavioral Health Day Programs.

K. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed must not consent to:

1. General anesthesia

2. Surgery

3. Testing for the presence of the human immunodeficiency virus

4. Blood transfusions

5. Abortions.

L. Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires DCS consultation and agreement.

M. If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

The AdSS must develop and make available to providers any form used to obtain general consent to treatment.

Informed Consent

A. In all cases where informed consent is required by this policy, informed consent must include at a minimum:

1. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

2. Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment

3. The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding

4. The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects

5. The ability of any consent given to be withheld or withdrawn in writing or orally at any time (when this occurs, the provider must document the member's choice in the medical record)

6. The potential consequences of revoking the informed consent to treatment

7. A description of any clinical indications that might require suspension or termination of the proposed treatment.

B. Documenting Informed Consent

1. Members, or if applicable, the member's parent, guardian or custodian, must give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

2. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established.

   If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the responsible person, refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner must document in the member's record that:

   a. The information was given

   b. The member refused to sign an acknowledgment

   c. The member gives informed consent to use psychotropic medication or telemedicine.

C. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

1. Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court

2. Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience.

   It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

D. Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

1. Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in the medical record. Informed consent is required prior to:

   a. Initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see Division Medical Policy Manual Policy 310-V)

      The use of Informed Consent/Assent for Psychotropic Medication Treatment Form (AMPM 310-V Attachment A) is recommended as a tool to review and document informed consent for psychotropic medications.

   b. Delivery of behavioral health services through telemedicine.

2. Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, prior to:

   a. Provision of Electro-Convulsive Therapy (ECT)

      ECT includes research activities, voluntary evaluation, and procedures or services with known substantial risks or side effects.

   b. Involvement of the member in research activities

   c. Provision of a voluntary evaluation for a member

      The use of Application for Voluntary Evaluation (AMPM 320-Q, Attachment A) is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations.

   d. Delivery of any other procedure or service with known substantial risks or side effects.

E. Written informed consent must be obtained from the member, legal guardian, or an appropriate court, prior to the member's admission to any medical detoxification program, inpatient facility, or residential program, operated by a behavioral health provider.

F. If informed consent is revoked, treatment must be promptly discontinued, except when abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

G. Informed Consent for Telemedicine

1. Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or legally authorized health care decision maker must be obtained. Refer to this Policy Manual, Policy 320-I.

2. Information regarding informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing information regarding informed consent, it must be communicated in a manner that the member and/or legal guardian can adequately understand.

3. Exceptions to this consent requirement include:

a. If the telemedicine interaction does not take place in the physical presence of the member

b. In an emergency situation in which the member or the member's legally authorized health care decision maker is unable to give informed consent

c. The transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

A. In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization, state-supported institution, or any person employed by any of these entities, may procure, solicit to perform, arrange for the performance of, or perform, mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

B. Non-Emergency Situations

1. When the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

a. Lawfully authorized legal guardian

b. Foster parent, group home staff or other person with whom the DCS has placed the child, or

c. Government agency authorized by the court.

2. If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

INDIVIDUAL/ENTITY	**DOCUMENTATION**
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: Foster parents Group home staff Foster home staff Relatives Other person/agency in whose care DCS has placed the child	None required (see note)

Note: If behavioral health providers doubt whether the person bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the person by DCS indicating that the person is an authorized DCS placement. If the person does not have this documentation, the provider may also contact the child's DCS caseworker to verify the person's identity.

3. For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

a. Evaluation and treatment for emergency conditions that are not life threatening, and

b. Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

4. Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

C. Emergency Situations

1. In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

2. Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

Special Requirements for Children

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or un-able to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment, and such consent should be obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

A. Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.

B. Substance Abuse Prevention Program and Evaluation Consent *(*AMPM 320-Q, Attachment B) must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of the Division and AHCCCS. The consent must satisfy all of the following requirements:

1. Contain language that clearly explains the nature of the screening program and when and where the screening will take place

2. Be signed by the child's parent or legal guardian

3. Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.

C. Completion of Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

320-R SPECIAL ASSISTANCE FOR MEMBERS WITH SERIOUS MENTAL ILLNESS

REVISION DATE: 9/15/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM Policy 1040; A.R.S. §§ 14-5304, 36-107, 36-501, 36-504, 36-509, 36-517.01, 41-3803, 41-3804; 9 A.A.C 21

PURPOSE

This policy applies to the Division's Administrative Services Subcontractor(s) (AdSS). The Division's AdSS must identify, document, notify and report members determined to have a serious mental illness (SMI) and meet the criteria for Special Assistance.

DEFINITIONS

Behavioral Health Residential Facility (BHRF) - as stated in A.A.C. R9-10-101, is a health care institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence.

Designated Representative - is a parent, guardian, relative, advocate, friend, or other person, designated orally or in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs.

Independent Oversight Committee (IOC) - is established by state statute (A.R.S. § 41-3804) to promote the rights of individuals who receive behavioral health services pursuant to Title 36, Chapters 5 and 34. There is one IOC established for each region, as well as the Arizona State Hospital, with each IOC providing independent oversight and review within its respective jurisdiction as defined in A.R.S. §§ 41-3803 and 41-3804, and A.A.C. R9-21-105.

Office of Human Rights (OHR) - is established within AHCCCS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates assist and advocate on behalf of members determined to have a serious mental illness with service planning, inpatient discharge planning, and resolving appeals and grievances.

Serious Mental Illness (SMI) - is a designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.

Special Assistance - is the support provided to a member designated as seriously mentally ill who is unable to articulate treatment preferences and/or participate effectively in the development of the service plan, Inpatient Treatment and Discharge Planning, grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

POLICY

The AdSS and subcontracted providers, if applicable, shall identify and submit notification to the Division of Developmental Disabilities (Division) and AHCCCS, Division of Community

Advocacy and Intergovernmental Relations, Office of Human Rights (OHR) of members who meet criteria for Special Assistance. The provider shall submit a notification whether or not the member's Special Assistance needs appear to be met by an involved guardian or

designated representative (e.g., family member or friend). The AdSS and subcontracted providers shall ensure that the individual designated to provide Special Assistance is involved at key stages of the grievance and appeals process.

A. GENERAL REQUIREMENTS

1. Criteria to deem a member to be in need of Special Assistance are as follows:

    a. A member is in need of Special Assistance if the member is unable to do any of the following:

        i. Communicate preferences for services;

        ii. Participate effectively in service planning or Inpatient Treatment and Discharge Planning (ITDP) development;

        iii. Participate effectively in the appeal, grievance, or investigation processes as specified in A.A.C R9-21, Article 4; and

    b. The member's inability to communicate preferences and participate effectively shall be due to at least one of the following:

        i. Cognitive ability/intellectual capacity (i.e., cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);

        ii. Language barrier (an inability to communicate, other than a need for an interpreter/translator); and/or

        iii. Medical condition including, but not limited to, traumatic brain injury, dementia, or severe psychiatric symptoms.

    c. A member who is subject to general guardianship has been found to be incapacitated as specified in A.R.S. § 14-5304 and automatically satisfies the criteria for Special Assistance.

    d. The existence of any of the following circumstances should prompt the AdSS or subcontracted provider to more closely review whether the member is in need of Special Assistance:

        i. Developmental disability involving cognitive ability;

        ii. Residence in a 24-hour BHRF setting;

        iii. Limited guardianship, or the AdSS or subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship; or

iv. Existence of a serious medical condition that affects the member's intellectual and/or cognitive functioning, such as dementia or traumatic brain injury.

2. The following criteria shall not be considered when making a determination as to whether a member is in need of Special Assistance. The member:

   a. Needs things explained in more basic terms;

   b. Is able but not willing to participate in treatment, service planning, ITDP, the appeal, grievance, or investigation processes;

   c. Can speak and advocate for themselves but presents with interpersonal issues that make working with the member challenging;

   d. Needs more regular and effective engagement from the treatment team; or

   e. Has a special need (e.g., unable to read or write, needs an interpreter).

3. The following individuals or entity may deem a member to be in need of Special Assistance:

   a. A qualified clinician providing treatment for the member,

   b. A Support Coordinator as specified in A.A.C. R9-21-101,

   c. A member of the clinical team as specified in A.A.C. R9-21-101,

   d. An AdSS,

   e. A program director of an AdSS' subcontracted provider,

   f. The Deputy Director of AHCCCS or designee; or

   g. A hearing officer assigned to an SMI appeal or grievance.

4. The AdSS and subcontracted providers shall, on an ongoing basis, assess whether members are in need of Special Assistance in accordance with the criteria set out in this policy. At a minimum this shall occur at the following stages:

   a. Assessment and annual updates,

   b. Development of or update to the service plan,

   c. Admission to a psychiatric inpatient facility,

   d. Development of or update to an ITDP,

   e. Initiation of the grievance or investigation processes,

f. Filing of an appeal, and

g. Existence of circumstances and/or other contributing factors which may be a basis for a grievance, an investigation, or an appeal.

5. The AdSS and subcontracted providers shall document in the member's medical record (e.g., on the assessment, service plan, ITDP, face sheet) each time a member is assessed for the need of Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the member is in need of Special Assistance, notification shall be provided to AHCCCS OHR by completing the notification form, Part A, in the AHCCCS QM Portal, at QMportal.azahcccs.gov, in accordance with the procedures below.

6. The AdSS shall also submit notification to the Division on a monthly basis by submitting members determined to have SMI receiving Special Assistance.

B. PROCESS FOR NOTIFICATION TO THE OFFICE OF HUMAN RIGHTS DIVISION

1. The AdSS and subcontracted providers shall submit a notification to AHCCCS OHR by completing Part A of the notification within five business days of identifying a member who is in need of Special Assistance and shall include:

   a. If the member requires immediate support (e.g., ITDP, active SMI appeal or grievance); the notification shall be submitted immediately.

   b. Notation if the member was or was not informed of the notification. If the member was not informed of the notification then it shall be documented with an explanation of why not, and

   c. A copy of the court-ordered guardianship and contact information of the appointed guardian if the member is under full legal guardianship.

      i. If guardianship documentation is not available at the time the member is identified as in need of Special Assistance, the notification is required to be submitted within the required timeframes, followed by submittal of the required documentation. The notification shall remain in pending status until the documentation is received. The AdSS shall ensure that the documentation is submitted timely.

2. The AdSS shall review the completed Part A section of the notification and:

   a. Verify the accuracy of all demographic information,

   b. Verify criteria and/or documentation submitted,

   c. Request additional information or missing information from the provider, if needed, and

   d. Move the notification forward in the process by submitting to AHCCCS OHR.

3. AHCCCS OHR will review the notification to ensure it contains all required information and respond within five business days of receipt. After review, AHCCCS OHR will:

   a. Contact the AdSS submitting the form for clarification, if needed.

   b. Designate which agency/individual will provide Special Assistance by completing Part B of the notification.

   c. Change the status of the notification to active.

4. The AdSS and subcontracted providers requesting an updated Part B, to change the individual/agency assigned to meet Special Assistance needs, shall submit a notification to AHCCCS OHR by updating the guardian/advocate information section on Part A of the notification and including any new documentation required (e.g., guardianship documentation). Requests to update Part B shall be submitted when any of the following changes occur:

   a. The individual or entity currently identified as providing Special Assistance is no longer actively involved or is unable to continue to meet the member's needs,

   b. There is a change in guardianship status,

   c. The member requests a change in the individual/agency meeting Special Assistance needs.

5. Notification to the Division

   a. The AdSS shall submit the monthly deliverable, Members Determined to have SMI Receiving Special Assistance, to the Division's Compliance Department as required in their Contract.

C. NOTIFICATION REQUIREMENTS FOR MEMBERS NO LONGER IN NEED OF SPECIAL ASSISTANCE

1. The AdSS or their subcontracted providers shall notify AHCCCS OHR within 10 days of an event or determination that a member receiving Special Assistance no longer meets criteria by completing Part C of the notification form within the portal noting:

   a. The reason(s) why Special Assistance is no longer required;

   b. The effective date;

   c. The name, title, phone number and e-mail address of the staff person completing the form; and

   d. The date the form is completed.

2. The following are instances that should prompt the AdSS or their subcontracted providers to submit a Part C:

a. The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria. This includes when it is determined that the SMI designation is no longer appropriate and the designation as been removed.

b. A Part C due to change in SMI designation shall not be completed until after the period to appeal has expired.

c. The member passes away.

d. The member enters a Department of Corrections facility.

e. The member moves out of state and no longer receives behavioral health services in Arizona.

f. The member elects not to receive services from the AdSS or TRBHA and the member is not transferred to another AdSS or TRBHA.

3. The AdSS or their subcontracted providers shall perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, in accordance with the Division AdSS Medical Manual Policy 1040, Outreach, Engagement, Re-engagement and Closure for behavioral health. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.

4. Submission of a Part C is not needed when a person transfers to another AdSS, as the Special Assistance designation follows the person and will be included in medical record during the transfer.

5. Upon receipt of Part C, AHCCCS OHR will review the content to confirm accuracy and:

a. Sends additional follow up questions to the AdSS or subcontracted provider, or

b. Changes the status of the notification to closed.

D. REQUIREMENTS TO ENSURE THE PROVISION OF SPECIAL ASSISTANCE

1. The AdSS and subcontracted providers must maintain open communication with the person (e.g., guardian, family member, designated representative) assigned to meet the member's Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

a. Behavioral health service planning and review, including any instance when the member makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, and physician and behavioral health case manager assignment).

b. Behavioral health service plan development and update shall be in accordance with AdSS Medical Policy 320-O, Service Planning, Assessments, and Discharge Planning.

c. ITDP, including any time a member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge.

d. Appeal process, including in circumstances that may warrant the filing of an appeal, so all Notices Adverse Benefit Determination or Notices of Decision issued to the member/guardian shall also be copied to the person designated to meet Special Assistance needs; and

e. Investigation or grievance, including when an investigation/grievance is filed and circumstances when initiating a request for an investigation/ grievance may be warranted.

2. If procedures described in the section above are delayed to ensure the participation of the person providing Special Assistance, the AdSS and subcontracted providers shall document the reason for the delay in the clinical record or in the investigation, grievance, or appeal file. If an emergency service is needed, the AdSS and their subcontracted providers shall ensure that the member receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.

3. The AdSS shall provide timely, relevant details and a copy of the original notification to the receiving entity and, when applicable, the support coordinator when a member in need of Special Assistance is:

   a. Admitted to an inpatient facility,

   b. Admitted to a BHRF setting, or

   c. Transferred to a different AdSS.

4. The AdSS and subcontracted providers shall ensure that Special Assistance member demographic information is updated within five business days of a change in any of the following sections of Part A:

   a. Member residence information; residence type, address, city, state, zip code, and phone number;

   b. Provider information; assigned provider agency, treatment team names, phone numbers and email addresses;

   c. Clinical information: diagnosis and clinical basis for Special Assistance (e.g., guardianship is assigned to a member who previously met criteria due to a cognitive barrier); or

   d. Guardian/advocate information; relationship to member, name, address, and phone number.

5. The AdSS shall periodically review whether the member's needs are being met by the person or agency designated to meet the member's Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they shall take further action to address the issue, which may include contacting the Division or AHCCCS OHR for assistance.

G. ADMINISTRATIVE REQUIREMENTS

1. The AdSS and subcontracted providers must clearly document in the member's medical record and in the behavioral health case management/client tracking system if a member is identified as in need of Special Assistance. This documentation should also include identification of the individual/agency currently assigned to provide Special Assistance, the relationship, and contact information including phone number and mailing address.

2. The AdSS must implement quality management measures to ensure the subcontracted providers implement requirements of this policy.

3. The AdSS must ensure that all applicable staff is trained regarding Special Assistance requirements.

4. The AdSS must share Special Assistance data with its subcontracted providers that provide behavioral health case management to members determined to have an SMI designation and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly).

5. The AdSS must also establish a process with its providers to obtain quarterly updates on persons currently identified as Special Assistance.

320-S BEHAVIOR ANALYSIS SERVICES

EFFECTIVE DATE: March 17, 2021
SUPERCEDES: 12/04/19

This policy applies to the Division's Administrative Services Subcontractors (AdSS).This Policy establishes requirements for Behavior Analysis Service delivery and treatment.

DEFINITIONS

1) Behavior Analysis Services - The use of behavior analysis to assist a person to learn new behavior, increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions in accordance with A.R.S. §32-2091.

2) Behavior Analysis Trainee - An individual who has met the credentialing requirements of a nationally recognized behavior analyst certification board as a board certified behavior analyst, assistant behavior analyst, or a matriculated graduate student or trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum, or supervised independent fieldwork. The practice under this role requires direct and ongoing supervision consistent with the standards set by a nationally recognized behavior analyst certification board as determined by the Arizona Board of Psychologist Examiners, and in accordance with A.R.S. §32-2091.08.

3) Behavior Analyst - A person who is licensed pursuant to A.R.S §32-2091 to practice behavior analysis.

4) Behavioral Health Professional –

    a) An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

        i) Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

        ii) Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,

    b) A psychiatrist as defined in A.R.S. §36-501,

    c) A psychologist as defined in A.R.S. §32-2061,

    d) A physician,

    e) A behavior analyst as defined in A.R.S. §32-2091,

    f) A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

    g) A registered nurse with:

    h) A psychiatric-mental health nursing certification, or

        i) One year of experience providing behavioral health services

ii) Behavioral Technician –For purposes of this Policy, a paraprofessional credentialed by a nationally recognized Behavior Analyst certification board or as specified in A.A.C. R9-10-101(39), an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

(1) If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

(2) Are provided with clinical oversight by a Behavioral Health Professional as specified in A.A.C. R9-10-101 (39).

Program Descriptions

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. ABA services are designed to accomplish one or more of the following: increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Refer to the *Behavioral Health Services Billing Matrix and Medical Coding Resources* on the AHCCCS website for more information regarding required coding information, including covered settings, modifiers for Behavior Analysis Trainee billing, or other billing/coding information.

Provider Qualifications

Behavior Analysis Services are directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees, and/or Behavior Technicians.

The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

The Behavior Analyst is responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician performs are consistent with his or her training and experience.

The Behavior Analyst is responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona state rules and regulations including those provisions set forth in A.R.S. §32-2091.

Behavior Analysis Assessments

Behavior Analysis Services are based upon assessment(s) that include Standardized and/or Non-standardized instruments through both direct and indirect methods.

A. Standardized instruments and procedures include, but are not limited to, checklists, rating

scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g., Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).

B. Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors.

Service Administration

Behavior Analysis Services are rendered according to an individualized behavior analysis Treatment Plan which will:

1) Be developed by a Behavior Analyst, based upon an assessment completed of the member and their behaviors as described above.

2) Be person-centered and individualized to the member's specific needs.

3) Specify the setting(s) in which services will be delivered.

4) Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).

5) Identify the baseline levels of target behaviors.

6) Specify long- and short- term objectives that are defined in observable, measurable, and behavioral terms.

7) Specify the criteria that will be used to determine treatment progress and achievement of objectives.

8) Include assessment and treatment protocols for addressing each of the target behaviors.

9) Clearly identify the schedule of services planned and roles and responsibilities for service delivery.

10) Include frequent review of data on target behaviors.

11) Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.

12) Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.

13) Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.

14) Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This may include Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, the Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, DCS, and/or other

state-funded programs, and others as applicable.

15) Result in progress reports at minimum, every six months. Progress reports includes, but are not limited to, the following components:

   i) Member Identification

   ii) Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications).

   iii) Assessment Findings (communication, social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns).

   iv) Outcomes (measurable objectives, progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation).

   v) Care Coordination (transition statement and individualized discharge criteria).

16) Be consistent with applicable professional standards and guidelines relating to the practice of ABA as well as Arizona Medicaid laws and regulations and Arizona state behavior analyst licensure laws and regulations (A.R.S. §32-2091).

320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

REVISION DATE: 10/1/2021, 6/16/2021
EFFECTIVE DATE: October 1, 2019

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) by establishing guidelines, as applicable, for the provision and coordination of behavioral health services regarding the pre-petition screening, court-ordered evaluation, and court-ordered treatment process.

DEFINITIONS

Court-Ordered Evaluation (COE) - Evaluation ordered by the court (A.A.C R9-21-101). The COE process as specified in this Policy.

Court-Ordered Treatment (COT) - Treatment ordered by the court (A.A.C R9-21-101). The COT process as specified in this policy.

Evaluation Agency - A health care agency licensed by the Arizona Department of Health Services that has been approved pursuant to A.R.S. Chapter 5 Title 36, providing those services required of such agency.

Mental Disorder - A substantial disorder of the individual's emotional processes, thought, cognition, or memory as defined in A.R.S. §36-501.

Pre-Petition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed individual. The purpose of the interview with the proposed member is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services as specified in A.R.S. § 36-501.

Screening Agency - A health care agency licensed by ADHS and that provides those services required of such agency pursuant to A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

Voluntary Evaluation - For purposes of this Policy, an inpatient or outpatient professional multidisciplinary service based on analysis of data describing the individual person's identity, biography, and medical, psychological and social conditions that is provided after a determination that an individual willingly agrees to consent to receive the service and is unlikely to present a danger to self or others until the service is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court-ordered evaluation and requires the informed consent of the individual. Additionally, the individual must be able to manifest capacity to give informed consent.

POLICY

This Policy outlines the processes and responsibilities applicable when it is necessary to initiate COE/COT proceedings detailed in A.R.S. §§ 36-501 et seq. This process is used to ensure the safety of an individual or the safety of others when, due to an individual's mental disorder, that individual is unable or unwilling to participate in treatment. Responsibilities

may vary for Pre-Petition Screening and COE based on contractual arrangements between AHCCCS, Contractors, and Arizona counties. AdSS shall ensure providers responsible for the COE/COT process adhere to requirements of this policy. When necessary, as specified in A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible individual may submit an application requesting an agency conduct a pre-petition screening when another individual is alleged to be, as a result of a mental disorder:

- Danger to Self (DTS),
- Danger to Others (DTO),
- Persistently or Acutely Disabled (PAD), or
- Gravely Disabled (GD).

If the individual who is the subject of a court-ordered commitment proceeding is subject to the jurisdiction of a tribal nation, rather than the state, the laws of that tribal nation will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order are found in this Policy.

Pre-Petition Screening includes an examination of the individual's mental status and/or other relevant circumstances by a designated Screening Agency. Upon review of the application, examination of the individual and review of other pertinent information, a licensed Screening Agency's medical director or designee will determine if the individual meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition application screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file an Application for Emergency Admission for Evaluation as specified in A.R.S. 36-524 for a COE. Based on the immediate safety of the individual or others, an emergency admission for evaluation may be necessary. The Screening Agency, upon receipt of the application shall determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application excluding weekends and holidays as specified in A.R.S. § 36-520.

Based on the COE, the Evaluating Agency may petition for COT on behalf of the individual. The subsequent hearing is the determination as to whether the individual will be court ordered to treatment as specified in A.R.S. § 36-539. COT may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the individual's designation as DTS, DTO, PAD, or GD. Individuals identified as:

- DTS may be ordered up to 90 inpatient days per year.
- DTO and PAD may be ordered up to 180 inpatient days per year, and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the individual's outpatient treatment. Before the court can order a mental health agency to supervise the individual's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the Pre-Petition Screening, COE and COT process, an individual who manifests the capacity to give informed consent pursuant to A.R.S. § 36-518 will be provided an opportunity to change the status to voluntary. Under voluntary status, the individual will voluntarily receive an evaluation and is unlikely to present as DTO/DTS during the time pending the voluntary evaluation.

Entities responsible for COE shall ensure the use of the following forms prescribed in 9 A.A.C. 21, Article 5 for individuals determined to have a Serious Mental Illness (SMI) and may also use these forms for all other populations.

Although the AdSS may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the AdSS must provide policies and procedures for providers outlining these processes.

A. Licensing Requirements

Behavioral health providers who are licensed by the ADHS/Division of Public Health Licensing as a COE or COT agency must adhere to ADHS licensing requirements.

B. Pre-Petition Screening

1. Unless otherwise indicated in an Intergovernmental Agreement (IGA) with a county, Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and COEs and are required to coordinate provision of behavioral health services with the member's AdSS or FFS program, responsible for the provision of behavioral health services. For additional information, visit the AHCCCS website, https://www.azahcccs.gov.

   During the Pre-Petition Screening, the designated Screening Agency must offer assistance, if needed, to the applicant in the preparation of the application for involuntary COE. Any behavioral health provider that receives an application for COE shall immediately refer the application for Pre-Petition Screening and petitioning for COE to the AdSS-designated Pre-Petition Screening agency or county facility.

   The AdSS shall develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must conform to the processes provided in A.R.S. §§ 36-501 et seq, and at a minimum address:

   a. Involuntary evaluation,

   b. Petitioning process,

   c. COE/COT process, including tracking the status of Court orders,

   d. Execution of Court orders, and

   e. Judicial Review.

C. Responsibility for Providing Pre-Petition Screening

When the AdSS is responsible through an IGA with a county for Pre-Petition

Screening and petitioning for COE, the AdSS must refer the applicant to a subcontracted Pre-Petition Screening Agency.

The Pre-Petition Screening Agency must follow these procedures:

1. Provide Pre-Petition Screening within 48 hours excluding weekends and holidays.

2. Prepare a report of opinions and conclusions. If Pre-Petition Screening was not possible, the Screening Agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the Pre-Petition Screening.

3. Ensure the agency's medical director or designee review of the report if the report indicates that there is no reasonable cause to support the allegations for COE by the applicant.

4. Prepare a Petition for COE and file the petition if the Screening Agency determines that due to a mental disorder, there is reasonable cause to believe that the individual meets the criteria set forth in § 36-521(D).

5. Ensure completion of Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the individual, without immediate hospitalization, is likely to harm themselves or others.

6. Contact the county attorney prior to filing a petition if it alleges that an individual is DTO.

D. Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the individual being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application must be filed. The petition must be filed at the appropriate agency as determined by the AdSS. Pursuant to A.R.S. § 36-501 et seq., when considering the emergent petition process, the following apply:

1. Only applications indicating DTS and/or DTO can be filed on an emergent basis.

2. The applicant shall have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements specified in A.R.S. § 36-524.

3. The applicant shall complete an Application for Emergency Admission for Evaluation.

4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior(s) may be called to testify in court if the application results in a petition for COE.

5. Immediately Upon receipt of an Application for Emergency Admission for

Evaluation and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then facility staff will immediately coordinate with local law enforcement for the detention of the individual and transportation to the appropriate facility.

6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48-hour timeframe identified above relating to an Application for Emergency Admission for Evaluation, the AdSS' Medical Director will be consulted to arrange for a review of the case.

7. The Application for Emergency Admission for Evaluation may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.

8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the Application for Emergency Admission for Evaluation in accordance with A.R.S. §§ 36-524(D) and 36-525(A), which outlines criteria for a peace officer to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.

10. During the emergency admission period of up to 23 hours the following occurs:

    a. The individual's ability to consent to voluntary treatment is assessed,

    b. The individual must be offered and receive treatment to which the individual may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e.,

       seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513, and

    c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determination that the individual no longer requires an involuntary evaluation.

E. Court-Ordered Evaluation

1. If, after review of the petition for evaluation, the individual is reasonably believed to be DTS, DTO, PAD, GD as a result of a mental disorder, the court can issue an order directing the individual to submit to an evaluation at a

designated time and place. The order must specify whether the evaluation will take place on an inpatient or an outpatient basis.

a. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer and delivered to an Evaluation Agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

2. If the Pre-Petition Screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file a petition for COE. When, through an IGA with a county, the AdSS is contracted to provide COE, they must adhere to the following requirements when conducting COEs:

a. An individual who is reasonably believed to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,

b. An individual admitted to an Evaluation Agency must receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,

c. A clinical record must be kept for each individual that details all medical and psychiatric evaluations and all care and treatment received by the individual,

d. An individual being evaluated on an inpatient basis must be released within 72 hours if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis, or unless an application for COT has been filed, and

e. On a daily basis, at minimum, an evaluation must be conducted throughout the COE process for the purpose of determining if an individual desires to be switched to a voluntary status or qualifies for discharge.

3. For information on individuals being released from COE, and on COE dispositions, refer to A.R.S. § 36-531.

F. Voluntary Evaluation

1. The AdSS shall require behavioral health providers who receive an application for Voluntary Evaluation to immediately refer the individual to a facility responsible for Voluntary Evaluations. The Voluntary Evaluation may be on an inpatient or outpatient basis. Voluntary Evaluation may be carried out only if chosen by the individual during the course of a Pre-Petition Screening after an application for evaluation has been made.

2. When an individual consents to Voluntary Evaluation, the evaluating agency shall follow these procedures:

a. Obtain the individual's informed consent prior to the evaluation,

b. Provide an evaluation at a scheduled time and place within five business days of the notice that the individual will voluntarily receive an evaluation, and

c. For inpatient Voluntary Evaluations, complete evaluations in less than 72 hours of receiving notice that the individual will voluntarily receive an evaluation.

3. The AdSS must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see AdSS Medical Policy 940):

a. A copy of the application for Voluntary Evaluation

b. A completed informed consent form (see AdSS Medical Policy 320-Q), and

c. A written statement of the individual's present medical condition.

G. Court-Ordered Treatment Following Civil Proceedings

Based on the COE, the evaluating agency may petition for COT. As specified in

A.R.S. §§ 36-501 et seq, the AdSS must require behavioral health providers to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD or PAD, and if no alternatives to COT exist, the Medical Director of the agency that provided the COE shall file a petition with the court for COT.

2. Any behavioral health provider filing a petition for COT must do so in

consultation with the individual's clinical team prior to filing the petition.

3. The petition shall be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation.

4. In cases of GD, a copy of the petition must be mailed to the public

fiduciary in the county of the individual's residence, or the county in which the individual was found before evaluation, and to any person nominated as guardian/legal representative. In addition, a copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

5. For information regarding court options for treatment, release, discharge, annual reviews, or COT violations, refer to A.R.S. §§ 36-540 et seq. For requirements relating to Judicial Review, see A.R.S. §§ 36-546 and 36-546.01.

a. For COT relating to DUI/Domestic Violence or other criminal offenses, refer to AdSS Operations Policy 423.

H. Individuals Who Are Title XIX/XXI Eligible and/or Determined to Have a

Serious Mental Illness

When an individual referred for COT is Title XIX/XXI eligible and/or determined or suspected to have an SMI, the AdSS must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the AdSS Medical Policy 320-P and conduct a behavioral health assessment to identify the individual's service needs, in conjunction with the individual's clinical team, as specified in the AdSS Medical Policy 320-O.

2. Provide necessary COT and other covered behavioral health services in

   accordance with the individual's needs, as determined by the individual's clinical team, family members, other involved parties.

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5, and 9 A.A.C. 21, Article 5.

I. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state issued COE or COT due to a behavioral health crisis occurs off reservation.

Several Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for COE and COT, however, each tribe has its own laws that must be followed for the tribal court process.

Additional information on the history of the tribal court process, legal documents and forms, a diagram of payment structures, as well as contact information for the tribes, tribal liaisons, TRBHAs, and tribal court representatives can be found on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment.

1. Tribal (COT) for American Indian tribal members in Arizona is initiated by the tribal behavioral health staff, the tribal prosecutor, or other individuals as authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether tribal COT is necessary. Tribal court orders specify the type of treatment needed.

2. Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure COT off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

3. The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition or "enforcement" of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal

court. Treatment facilities must provide treatment as identified by the tribe and recognized by the state. Attachment B is a flow chart demonstrating the communication between tribal and state entities in accordance with A.R.S § 12-136.

4. Contractors and providers shall comply with notice requirements as specified in A.R.S. §12-136(B) and A.R.S. §36-541.01.

5. The AdSS and providers shall comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX individuals with an SMI determination. When tribal providers are also involved in the care and treatment of court ordered tribal members, the AdSS and providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT and when members are transitioned to services on the reservation, as applicable. AdSS are encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

6. The enforcement process must run concurrently with the tribal staff's initiation of the tribal court-ordered process in an effort to communicate and ensure clinical coordination with the appropriate AdSS. This clinical communication and coordination with the AdSS is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital must be the last placement alternative considered and used in this process.

7. The Court must consider all available and appropriate alternatives for the treatment and care of the member. The Court must order the least restrictive treatment alternative available (A.R.S. § 36-540(B)). The AdSS are expected to partner with American Indian tribes, TRBHAs, and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, AHCCCS eligible American Indians may be covered and/or coordinate behavioral health services through a TRBHA, THP (Division for THP DDD ALTCS members), AHCCCS contractor, Tribal ALTCS, IHS, or 638 tribal provider.

J. Reporting Requirements

COE and COT processes, tracking, and reporting shall align with and adhere to the requirements of A.R.S. Title 36 Chapter 5 and A.A.C. Title 9 Chapter 21, including requirements for COE and COT forms as delineated in A.A.C. Title 9 Chapter 21 Article 5:

- Exhibit A - Application for Involuntary Evaluation
- Exhibit B - Petition for Court-Ordered Evaluation
- Exhibit C - Application for Emergency Admission for Evaluation
- Exhibit D - Application for Voluntary Evaluation

- Exhibit E - Affidavit
- Exhibit F - Petition for Court-Ordered Treatment
- Exhibit G - Demand for Notice by Relative or Victim
- Exhibit H - Petition for Notice
- Exhibit I - Application for Voluntary Treatment

K. Reimbursement

1. Reimbursement for court-ordered screening and evaluation services are the responsibility of the county pursuant to A.R.S. § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22.

2. Refer to AdSS Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE.

3. Title XIX/XXI funds must not be used to reimburse COE services.

4. For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual shall be the responsibility of the AdSS of enrollment.

320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

REVISION DATES: 1/10/2024, 4/6/2022, 6/16/2021, 4/22/2020
REVIEW DATE: 6/3/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 32-2061, 32-2091, 32-3251 et seq., 36-501; A.A.C. R9-10-101, 702, 707, 708, 715, 814; International Classification of Diseases, 10th Revision, Clinical Modification.

PURPOSE

This policy establishes requirements of the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) for the provision of care and services in a Behavioral Health Residential Facility.

DEFINITIONS

1. "Adult Recovery Team" means a group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the Member, service planning, and service delivery.

2. "Behavioral Health Condition" means a mental, behavioral, or neurodevelopmental disorder diagnosis defined by International Classification of Diseases, 10th Revision, Clinical Modification.

3. "Behavioral Health Professional" means:

   a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

      i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

      ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101;

   b. A psychiatrist as defined in A.R.S. § 36-501;

   c. A psychologist as defined in A.R.S. § 32-2061;

   d. A physician;

   e. A behavior analyst as defined in A.R.S. §32-2091;

   f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

   g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral

health services.

4. "Behavioral Health Residential Facility" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to a Member experiencing a behavioral health issue that limits the Member's ability to be independent or causes the Member to require treatment to maintain or enhance independence.

5. "Behavioral Health Residential Facility Staff" means any employee of the Behavioral Health Residential Facility, including administrators, Behavioral Health Professionals and Behavioral Health Technicians.

6. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care institution's policies and procedures, with clinical oversight by a behavioral health professional, and that if provided in a setting other than a licensed health care institution would require the individual to be licensed as a behavioral health professional under A.R.S Title 32, Chapter 33.

7. "Child and Family Team" means a group of individuals that includes, at a minimum, the child, the child's family, a behavioral health

representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. The size, scope, and intensity of involvement by team members is determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective Service Plan and can expand and contract as necessary to be successful on behalf of the child.

8. "Crisis and Safety Plan" means a written description for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis; establishes goals to prevent or ameliorate the effects of a crisis, and specifically address techniques for establishing safety, identification of realistic interventions, physical limitations or unique needs of the Member, trauma informed, and developed in alignment with the Member's Service and Treatment Plans, and any existing behavior plan, if applicable, and adherence to court-ordered treatment when applicable.

9. "Medication Assisted Treatment" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

10. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

11. "Outpatient Treatment Team" means a group of individuals working in collaboration with the Behavioral Health Residential Facility and are actively involved in a Member's assessment, service planning, and service delivery. Outpatient Treatment Team as used throughout this policy can indicate a Child and Family Team, Adult Recovery Team, Tribal Regional Behavioral Health Authority, American Indian Medical Home, Indian Health Services, Tribally operated 638 Facility, or the Division.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

13. "Second Level Review" means a review performed by a Division Medical Director who has clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving

medically appropriate and high quality care.

14. "Secure Behavioral Health Residential Facility" means the same as specified in A.R.S. § 36-425.06(B) and A.A.C. R9-10-101 (36).

15. "Service Plan" means a complete written description of all covered health services and other informal supports, including individualized goals, family support services, care coordination activities, and strategies to assist the Member in achieving an improved quality of life.

16. "Treatment Plan" means a written description of all services to be provided by a Behavioral Health Residential Facility. The Treatment Plan is based on the intake assessments, outpatient Service Plan, and includes input from the Outpatient Treatment Team.

POLICY

A. BEHAVIORAL HEALTH RESIDENTIAL FACILITY REQUIREMENTS

1. The AdSS shall adhere to the following:
    a. Care and services provided in a Behavioral Health Residential Facility (BHRF):
        i. Are based on a 24-hour day per diem rate;

ii. Require prior and continued authorization; and

iii. Do not include room and board.

b. The BHRF level of care is inclusive of all treatment services provided by the BHRF in accordance with the Treatment Plan created by the Outpatient Treatment Team.

c. BHRFs are Arizona Department of Health Services licensed facilities in accordance with A.A.C. Title 9, Chapter 10, Article 7.

d. Refer to AdSS Operations Policy 414 for request timeframes and requirements regarding prior authorization.

e. Respond to all authorization requests for BHRF services as expedited requests within 72 hours of receipt of authorization.

f. Send all documentation associated with a denial of admission to a BHRF to the Division within one business day for a Second Level Review.

g. Do not require prior and continued authorization for admission to a Secure BHRF.

h. Adhere to the court order, as specified in A.R.S §

36-550.09, for admission and duration of stay in a Secure BHRF.

2. The AdSS shall have a process in place to ensure notification is sent to the Primary Care Provider, Behavioral Health Provider, and the Division's Support Coordinator upon admission to and discharge from the BHRF.

3. The AdSS shall develop medically necessary criteria for admission to, continued stay in, and discharge from BHRFs, and approved by the Division prior to publishing on the AdSS' website.

B. CRITERIA FOR ADMISSION

1. The AdSS shall develop admission criteria for medical necessity that contains the following elements:

   a. Member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment level of care.

   b. The Behavioral Health Condition causing the functional or psychosocial impairment is evidenced in the assessment by

the following:

i. At least one area of significant risk of harm within the past three months as a result of:

a) Suicidal, aggressive, self-harm, homicidal thoughts or behaviors without current plan or intent;

b) Impulsivity with poor judgment or insight;

c) Maladaptive physical or sexual behavior;

d) Member's inability to remain safe within their environment despite environmental supports; or

e) Medication side effects due to toxicity or contraindications; and

ii. At least one area of serious functional impairment as evidenced by:

a) Inability to complete developmentally appropriate self-care or self-regulation due to a Behavioral Health Condition;

b) Neglect or disruption of ability to attend to

majority of basic needs, such as personal safety, hygiene, nutrition or medical care;

c) Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders;

d) Frequent withdrawal management services, which can include detox facilities, Medication Assisted Treatment, and ambulatory detox;

e) Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications; or

f) Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

c. A behavioral health need for 24-hour supervision to develop adequate and effective coping skills that will allow the Member to live safely in the community.

d. Anticipated stabilization cannot be achieved in a less restrictive setting.

e. Evidence that behavioral health treatment in a less restrictive level of care has not been successful or is not available, therefore warranting a higher level of care.

f. Member or Member's Responsible Person agrees to participate in treatment.

g. Agreement to participate is not a requirement for individuals who are court-ordered to a Secure BHRF.

h. Member's Outpatient Treatment Team is part of the pre-admission assessment and Treatment Plan formulation unless the Member is evaluated by a crisis provider, emergency department, or behavioral health inpatient facility.

i. The BHRF shall notify the Member's Outpatient Treatment

Team of admission prior to creation of the BHRF Treatment Plan.

C. EXPECTED TREATMENT OUTCOMES

1. The AdSS shall require treatment outcomes to align with the following:
   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in AdSS Medical Manual Policy 430;
   b. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems; and
   c. The Member's individualized basic physical, behavioral, and developmentally-appropriate needs.
2. The AdSS shall require treatment goals to be developed in accordance with the following:
   a. Specific to the Member's Behavioral Health Condition;
   b. Measurable and achievable;
   c. Unable to be met in a less restrictive environment or lower level of care;

d. Based on the Member's unique needs and tailored to the Member and family/Responsible Person choices where possible; and

e. Support the Member's improved or sustained functioning and integration into the community.

D. EXCLUSIONARY CRITERIA

1. The AdSS shall not allow admission to a BHRF to be used as a substitute for the following:

   a. Detention or incarceration;

   b. Ensuring community safety in circumstances where a Member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment;

   c. Providing safe housing, shelter, supervision, or permanency placement;

   d. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs, including situations when the Member or Member's Responsible Person is unwilling to participate in the less restrictive alternative; or

   e. An intervention for runaway behaviors unrelated to a

Behavioral Health Condition.

E. CRITERIA FOR CONTINUED STAY

1. AdSS shall develop medical necessity criteria for continued stay that contains the following elements:
   a. Assessment of continued stay by BHRF Staff in coordination with the Outpatient Treatment Team during each Treatment Plan review and update.
   b. Assessment of progress towards the treatment goals and continued display of risk and functional impairment.
   c. Treatment interventions, frequency, crisis and safety planning, and targeted discharge adjusted accordingly to support the need for continued stay.
2. The AdSS shall consider the following criteria when determining continued stay:
   a. The Member continues to demonstrate significant risk of harm or functional impairment as a result of a Behavioral Health Condition; and
   b. Providers and supports are not available to meet current

behavioral and physical health needs at a less restrictive lower level of care.

F. DISCHARGE READINESS

1. The AdSS shall develop medical necessity criteria for discharge readiness that contains the following elements:
    a. Discharge planning begins at the time of admission, and
    b. Discharge readiness is assessed by the BHRF Staff in coordination with the Outpatient Treatment Team during each Treatment Plan review and update.
2. The AdSS shall consider the following criteria when determining discharge readiness:
    a. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals;
    b. Functional capacity is improved;
    c. Essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care;
    d. Member is able to self-monitor for health and safety, or a caregiver is available to provide monitoring in a less

restrictive level of care; and

e. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

G. ADMISSION, ASSESSMENT, TREATMENT, AND DISCHARGE PLANNING

1. The AdSS shall establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among BHRF providers in accordance with A.A.C. R9-10-707 and 708, and as stated below:

   a. Except as provided in subsection A.A.C. R9-10-707(A)(9), a behavioral health assessment for a Member is completed before treatment is initiated and within 48 hours of admission.

   b. The Outpatient Treatment Team is included in the development of the Treatment Plan within 48 hours of admission.

   c. BHRF documentation reflects:

      i. All treatment services provided to the Member;

      ii. Each activity documented in a separate,

individualized medical record, including the date, time, and behavioral health professional conducting treatment activity;

iii. Which Treatment Plan goals are being achieved;

iv. Progress towards desired treatment goal; and

v. The frequency, length, and type of each treatment service or session.

d. BHRF Staff coordinates care with the Outpatient Treatment Team throughout the admission, assessment, treatment, and discharge process.

e. The BHRF Treatment Plan connects back to the Member's Service Plan.

f. For a Secure BHRF, the Treatment Plan aligns with the court-ordered treatment plan.

g. A discharge plan is created during the development of the initial Treatment Plan and reviewed and updated at each review thereafter.

h. A discharge plan documents the following:

i. Clinical status for discharge;

ii. The Responsible Person and Outpatient Treatment Team understands the follow-up treatment, Crisis and Safety Plan; and

iii. Coordination of care and transition planning are in process.

i. The BHRF Staff and the Outpatient Treatment Team meet to review and modify the Treatment Plan at least once a month.

j. A Treatment Plan may be completed by a Behavioral Health Professional, or by a Behavioral Health Technician with oversight and signature by a Behavioral Health Professional within 24 hours.

k. Implementation of a system to document and report on timeliness of the Behavioral Health Professional signature/review when the Treatment Plan is completed by a Behavioral Health Technician.

l. BHRF providers have a process to actively engage the family and Responsible Person, or other designated

individuals, in the treatment planning process as appropriate.

m. Clinical practices, as applicable to services offered and population served, demonstrate adherence to best practices for treating specialized service needs that includes:

i. Cognitive/intellectual disability;

ii. Cognitive disability with comorbid Behavioral Health Condition(s);

iii. Older adults and co-occurring disorders; and

iv. Comorbid physical and Behavioral Health Condition(s).

n. Members in a BHRF level of care cannot receive services under another level of care while receiving services in a BHRF.

o. Services deemed medically necessary and not offered at the BHRF are documented in the Member's Service Plan with a description of the need, identified goals, and

identification of providers who will be meeting the need.

p. The following services are made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

i. Counseling and Therapy (group or individual): Behavioral health counseling and therapy shall not be billed on the same day as BHRF services unless specialized behavioral health counseling and therapy have been identified in the Service Plan as a specific Member need that cannot otherwise be met as required within the BHRF setting.

ii. Skills Training and Development:

a) Independent Living Skills,

b) Community Reintegration Skill Building, and

c) Social Communication Skills.

iii. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services:

a) Symptom management;

b) Health and wellness education;

c) Medication education and self-administration

skills;

d) Relapse prevention;

e) Psychoeducation services and ongoing support to maintain employment work/vocational skills, educational needs assessment and skill building;

f) Treatment for substance use disorder; and

g) Personal care services.

H. BHRF AND MEDICATION ASSISTED TREATMENT

The AdSS shall ensure BHRF providers have written policies and procedures to ensure Members on Medication Assisted Treatment are not excluded from admission and are able to receive Medication Assisted Treatment in compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session.

I. BHRF WITH PERSONAL CARE SERVICE LICENSE

1. The AdSS shall ensure that BHRFs providing personal care services are licensed to provide personal care services and that the services are offered in accordance with A.A.C. R9-10-702 and A.A.C. R9-10-715.

2. The AdSS shall ensure that BHRF providers can meet all identified needs in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E).

SUPPLEMENTAL INFORMATION

Examples of Personal Care Services

- ACE wraps, arm and leg braces
- Administration of oxygen
- Application and care of orthotic devices
- Application and care of prosthetic devices
- Application of bandages and medical supports, including high elastic stockings
- ACE wraps, arm and leg braces
- Application of topical medications
- Assistance with ambulation
- Assistance with correct use of cane/crutches

- Bed baths
- Blood sugar monitoring, Accu-Check diabetic care
- Care of hearing aids
- Catheter care
- Denture care and brushing teeth
- Dressing member
- G-tube care
- Hair care, including shampooing
- Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
- Measuring and giving insulin, glucagon injection
- Measuring and recording blood pressure
- Non-sterile dressing change and wound care
- Ostomy and surrounding skin care
- Passive range of motion exercise
- Radial pulse monitoring
- Respiration monitoring
- Shaving
- Shower assistance using shower chair
- Skin and foot care

- Skin maintenance to prevent and treat bruises, injuries, pressure sores and infections. (Members with a stage 3 or 4 pressure sore are not to be admitted to a BHRF pursuant to A.A.C. R9-10-715(3).
- Supervising self-feeding of members with swallowing deficiencies
- Use of chair lifts
- Use of pad lifts

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:58 MST)
Anthony Dekker, D.O.

320-W THERAPEUTIC FOSTER CARE FOR CHILDREN

REVISION DATE: 1/10/2024
EFFECTIVE DATE: March 24, 2021
REFERENCES: A.R.S. Title 14, Chapter 5, Article 2 or 3; A.R.S. §§ 8-451.01, 8-514.05, 36-3221, 36-3231 or 36-3281; A.A.C. R9-10-101; ACOM Policy 414

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS) and establishes requirements for the provision of Therapeutic Foster Care (TFC) and services provided to eligible Division Members enrolled in a Division subcontracted health plan.

DEFINITIONS

1. "Agency Worker" means a Therapeutic Foster Care Agency Worker that meets the minimum qualifications at the level of Behavioral Health Technician with a minimum of one year of experience in a human services field.
2. "AHCCCS" means the Arizona Health Care Cost Containment System.
3. "Arizona Department of Child Safety" means the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

a. Investigate reports of abuse and neglect.

b. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.

c. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.

d. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthening the family and provide prevention, intervention, and treatment services pursuant to A.R.S. Title 8, Chapter 4.

4. "Behavioral Health Professional" means:

a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-10;

b. A psychiatrist as defined in A.R.S. § 36-501;

c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. § 32-2091;

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral health services.

5. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care institution's policies and procedures, and with clinical oversight by a Behavioral Health Professional, that if provided in a setting other than a health care institution would require the individual to be licensed as a Behavioral Health Professional under A.R.S Title 32, Chapter 33.

6. "Caregiver" means an adult who is providing for the physical, emotional, and social needs of a child.

7. **"**Child and Family Team" means a defined group of individuals that includes the child and their family, a behavioral health provider, and any individuals important in the child's life that are identified and

invited by the child and family to participate.

8. "Crisis Plan" means a written plan established by the Member that is designed to prevent or reduce the effects of a behavioral health crisis. This plan identifies what is or is not helpful in crisis prevention through the identification of contacts and resources, and actions to be taken by the Member, family, Responsible Person, parents, guardians, friends, or others.
9. "Immediate Jeopardy" means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member.
10. "Service Plan" means a comprehensive written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the Member in achieving an improved quality of life. The Service Plan is created and managed by the CFT. It is a dynamic document that is regularly updated to adequately match the strengths and needs of the Member and family.
11. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
12. "Respite Care" means short-term relief for primary caregivers.

13. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
14. "Telemedicine" means the practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the Member.
15. "Therapeutic Foster Care" means a covered behavioral health service that provides daily behavioral interventions within a licensed family setting and is designed to maximize the Member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the Member's comprehensive Service Plan, as appropriate.
16. "Therapeutic Foster Care Agency Provider" means a TFC agency provider credentialed by a Managed Care Organization to oversee professional TFC Family Providers and holds contracts with pertinent health plans or the Department of Child Safety to provide TFC services

to children.

17. "Therapeutic Foster Care Family Provider" means specially trained adult(s) in a family unit licensed by the Department of Child Safety and endorsed to provide TFC services to children.

18. "Therapeutic Foster Care Treatment Plan" means a written plan that details the specific behavioral goals that the TFC Family and TFC Agency Providers will help the Member achieve during the Member's time in TFC. These TFC treatment goals are explicit, observable, attainable, tailored to the Member's strengths and needs, and align with the comprehensive Service Plan of the CFT. The TFC Treatment Plan outlines the steps the TFC Family and TFC Agency Providers will implement to help the Member attain the TFC treatment goals and successful discharge from TFC.

POLICY

A. THERAPEUTIC FOSTER CARE

1. The AdSS shall ensure TFC Agency Providers adhere to the following requirements:
    a. Programmatic support is available to the TFC Family Providers 24 hours per day, seven days per week.
    b. Care and services provided in TFC:

i. Are based on a 24-hour day per diem rate;

ii. Require prior and continued authorization; and

iii. Do not include room and board.

c. TFC services are provided for no more than three children in a professional foster home.

2. The AdSS shall ensure appropriate notification is sent to the primary care provider and behavioral health home agency or TRBHA, as applicable, upon admission to and discharge from TFC.

3. The AdSS shall ensure TFC Family Providers and TFC Agency Providers adhere to the Department of Child Safety (DCS) policies and procedures for children involved with DCS.

B. CRITERIA FOR ADMISSION

1. The AdSS shall develop medical necessity criteria for admission to TFC, and submit to the Division for approval, that contains the following elements:

a. Recommendation for TFC comes through the Child and Family Team (CFT) process.

b. Following an assessment by a licensed Behavioral Health

Professional (BHP), the Member has been diagnosed with a behavioral health condition that reflects the symptoms and behaviors necessary to warrant a request for TFC.

c. There is evidence that the Member has had a disturbance of mood, thought, or behavior within the past 90 days that renders the Member incapable of independent or age-appropriate self-care or self-regulation as a result of the Behavioral Health Condition, and that this moderate functional or psychosocial impairment, per assessment by a BHP:

   i. Cannot be reasonably expected to improve in response to a less intensive level of care; and

   ii. Does not require or meet clinical criteria for a higher level of care; or

   iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

d. At the time of admission, in collaboration with the CFT and

other individuals as applicable, there are documented plans for discharge and transition that identifies:

i. Tentative living arrangement, and

ii. Recommendations for aftercare treatment based on treatment goals.

C. EXCLUSIONARY CRITERIA

1. The AdSS shall not allow admission to TFC to be used as a substitute for the following:

   a. Detention or incarceration;

   b. Ensuring community safety in an individual exhibiting primarily conduct disorder behaviors;

   c. Providing safe housing, shelter, supervision, or permanency placement;

   d. The Responsible Person's capacity or other agency's capacity to provide for the Member; or

   e. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs, including when the Responsible Person is

unwilling to participate in the less restrictive alternative.

D. EXPECTED TREATMENT OUTCOMES

1. The AdSS shall require treatment outcomes to align with:
    a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100; and
    b. The Member's individualized physical, behavioral, and developmentally appropriate needs.
2. The AdSS shall require that the treatment goals for a Member's time in TFC are as follows:
    a. Specific to the Member's behavioral health condition that warranted treatment;
    b. Measurable and achievable;
    c. Cannot be met in a less restrictive environment;
    d. Based on the Member's unique needs;
    e. Include input from the Member's family, Responsible Person, and other designated representatives where

applicable; and

f. Support the Member's improved or sustained functioning and integration into the community.

3. The AdSS shall ensure active treatment with the services available at this level of care can reasonably be expected to:

a. Improve the Member's condition in order to achieve discharge from TFC at the earliest possible time, and

b. Facilitate the Member's return to primarily outpatient care in a non-therapeutic, non-licensed setting.

E. CRITERIA FOR CONTINUED STAY

1. The AdSS shall develop medical necessity criteria for continued stay, and submit to the Division for approval, that contains the following elements:

a. The Member continues to meet the diagnostic threshold for the behavioral health condition that warranted admission to TFC.

b. It can reasonably be expected that continued treatment will improve the Member's condition to the point that TFC

will no longer be needed.

c. The CFT is meeting at least monthly to review progress and revise the TFC Treatment Plan and Service Plan to respond to any lack of progress.

d. The transitioning Caregiver after discharge has been identified and is actively involved in the Member's care and treatment, if applicable.

e. The Member continues to demonstrate moderate functional or psychosocial impairment within the past 90 days as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or age-appropriate self-care or self-regulation.

f. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors that were identified as reasons for admission to TFC, and treatment is empowering the Member to gain skills to successfully function in the community.

F. CRITERIA FOR DISCHARGE

1. The AdSS shall develop medical necessity criteria for discharge

from TFC, and submit to the Division for approval, that contains the following elements:

a. Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.

b. The Member's functional capacity is improved and the Member can be safely cared for in a less restrictive level of care.

c. The Member can participate in age-appropriate self-monitoring and follow-up services or a Caregiver is available to provide monitoring in a less restrictive level of care.

d. Appropriate services, providers, and supports are available to meet the Member's current behavioral health needs at a less restrictive level of care.

e. There is no evidence to indicate that continued treatment in TFC would improve the Member's clinical outcome.

f. There is potential risk that continued stay in TFC may precipitate regression or decompensation of the Member's

condition.

g. A current clinical assessment of the Member's symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in a TFC setting is no longer adequate to provide for the safety and treatment.

G. DISCHARGE PLANNING PROGRAM REQUIREMENTS

1. The AdSS shall require TFC Agency Providers to adhere to the following discharge planning program requirements:

   a. Discharge planning details are included in the TFC Treatment Plan, updated monthly, and align with the Service Plan.

   b. Discharge plans are completed using the approved standardized criteria.

   c. Discharge plans include identification of and consistent work with Responsible Persons, if applicable.

   d. The TFC team continues to plan for discharge as soon as an appropriate lower level of community-based care is identified.

e. Successful discharge planning includes engagement of the receiving caregiver to participate in transitionary visits.

f. The TFC team assesses the needs of the receiving caregiver and provides the appropriate coaching and mentorship.

g. The CFT shall review and approve the discharge plans to ensure successful implementation of discharge planning details such that sustainable transition into a less restrictive setting is possible.

h. If a decision is made to move the Member to a higher level of care, the TFC Family Provider and TFC Agency Provider work in collaboration with the CFT to make the transition as seamless as possible.

H. TREATMENT PLANNING PROGRAM REQUIREMENTS

1. The AdSS shall require the TFC Agency Provider to ensure the TFC Treatment Plan includes:

   a. Development in conjunction with the CFT;

   b. Strategies to address TFC Family Provider needs and successful transition for the Member to begin service with

the TFC Family Provider, including pre-service visits, when appropriate, as well as respite planning;

c. Complementing and not conflicting with the Service Plan and other defined treatments, and reference to the Member's:

   i. Current physical, emotional, behavioral health, and developmental needs;

   ii. Current educational placement and needs;

   iii. Current medical treatment;

   iv. Current behavioral treatment through other providers; and

   v. Current prescribed medications.

d. Updating Member's current Crisis Plan in alignment with the TFC setting;

e. Addressing safety, social and emotional well-being, discharge criteria, acknowledgement of Member's permanency objectives and post-discharge services; and

f. Short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the Service

Plan.

g. When age and developmentally appropriate, youth and biological family, kinship family, and adoptive family participation in development of the TFC Treatment Plan is required;

h. Specific elements that build on the Member's strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement; and

i. Specifics to coordinate with natural supports and informal networks as a part of treatment.

J. If the TFC Treatment Plan includes co-parenting engagement with the Member's Caregiver, development of specific goals to prepare the receiving Caregiver and successfully transition the Member to the new placement;

k. Plans for engagement of the Member's biological family, kinship family, adoptive family and or transition foster

family, and other natural supports that can support the Member during TFC placement and after transition;

l. Respite planning;

m. Review by:

i. The TFC Family Provider and TFC Agency Provider at each home visit;

ii. The TFC Agency Provider and clinical supervisor at each staffing; and

iii. The TFC Agency Provider and CFT at each revision or at minimum quarterly.

n. Documentation of the TFC Treatment Plan which is kept by the TFC Family Provider and the TFC Agency Provider and shared with the CFT.

I. THERAPEUTIC FOSTER CARE ROLES, RESPONSIBILITIES AND QUALIFICATIONS

1. The AdSS shall credential TFC Agency Providers.

2. The AdSS shall require that the TFC Agency Providers do the

following:

a. Ensure TFC Family Providers comply with all applicable state and local licensing requirements, including application, training, life safety inspections, and administrative requirements.

b. Ensure submission of deliverables.

c. Conduct one home visit per week during the initial six weeks of placement; these visits may be in person or Telemedicine.

d. Conduct a minimum of two home visits per month for continued stay beyond the initial six weeks of placement, with supporting documentation of each visit, including:

   i. Review of the TFC Treatment Plan with the TFC Family Provider;
   ii. Review case files and required documentation; and
   iii. Check medical records and medication logs.

e. Complete all AHCCCS required group biller requirements.

f. Conduct TFC Family Provider recruitment to maintain and

increase the number of providers that can meet the needs of Members receiving TFC services.

g. Conduct ongoing training per state licensing rule that develops the skills of TFC Family Providers to enable them to meet the needs of Members.

3. The AdSS shall require TFC Agency Providers to have staff to operate resource teams to support the TFC Family Provider as follows:

a. Beginning at the level of the Agency Worker, extending to the clinical supervisor;

b. Provide oversight by one or more independently licensed BHPs;

c. Work in concert, applying the specialized skills and knowledge for service planning, training, and support of direct service providers and the CFT; and

d. Each member of the team shall have in-depth familiarity with the strengths and needs of the TFC Family Provider in order to be effective resources in the provision of care,

developing training plans, and assisting in matching Members to service environments.

4. The AdSS shall require TFC Agency Providers to have a documented agency crisis response policy that specifies:

   a. Supervisor's availability and the use of crisis response provider to augment hours of availability;

   b. The TFC Agency Provider fulfilling the role of first-line support for the TFC Family Provider and Member during times of crisis;

   c. Access to a TFC Agency Provider or appropriate agency staff 24 hours a day, seven days a week; and

   d. Escalation to the appropriate TFC Agency Provider's clinical leadership is available at all times.

5. The AdSS shall require TFC Agency Providers to coordinate the TFC Treatment Plan with the Service Plan and incorporate the TFC Family Provider's participation in CFT meetings.

6. The AdSS shall require TFC Agency Providers to support the TFC Family Provider through clinical supervision available upon

request or as the TFC Agency Worker that identifies needs, including:

a. Provide training and specific skill building to enhance the family's ability to stabilize behaviors and intervene as challenges arise;

b. Facilitate respite;

c. Attend all CFT, court, and professional meetings with or on behalf of the family; and

d. Contact between the TFC Family Provider and other caregivers in preparation for discharge.

7. The AdSS shall require the TFC Agency Providers to ensure the following documentation, assessments, and records are updated and available:

a. Current TFC Treatment Plan;

b. Current Service Plan;

c. Crisis Plan;

d. Discharge plan;

e. Social history information;

f. Previous and current (within a year of referral date) behavioral health annual assessments, psychiatric evaluations, psychological evaluations;

g. School and educational information;

h. Medical information,

i. Previous placement history and outcomes; and

j. Member and family strengths and needs, including skills, interests, talents, and other assists.

8. The AdSS shall require TFC Agency Providers to have Agency Workers who are:

a. Qualified, at minimum, at the level of Behavioral Health Technician with a minimum one year of experience in a human services field.

b. Supervised by staff that possess a master's degree in a behavioral health field, and licensed in the state of Arizona, with a minimum two years of experience in a human

services field.

c. The primary agency representative at the CFT meetings who shall:

i. Be present to review the Service Plan,

ii. Document progress to those plans,

iii. Support the CFT,

iv. Support the TFC Family Provider, and

v. Participate in the CFT meetings.

9. The AdSS shall require TFC Agency Providers to have Agency Workers responsible for the following:

a. Lead the development of the TFC Treatment Plan with the TFC Family Provider and obtain clinical supervisor review.

b. Ensure the TFC Family Provider completes full and accurate clinical documentation of interventions on the TFC Treatment Plan to demonstrate progress toward meeting treatment needs is fully captured and provides an accurate record of case progress.

c. Ensure the TFC Treatment Plan is shared with the behavioral health agency and other treating providers or individuals, as applicable, as part of the Member's Service Plan to assure care coordination.

d. Monitor the number of Members assigned to a single Agency Worker.

   i. The preferred maximum number of Members assigned to a single Agency Worker is 10 Members.

   ii. The supervisor may lower the number of assigned Members to an Agency Worker if additional time is needed for one or more assigned families/members for oversight and support.

e. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider a minimum of once a week for the first six weeks of placement.

f. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider every other week or as needed for the remainder of the treatment, with one

visit per month with the TFC Member to assess physical, emotional, and behavioral health needs are being met.

g. Encourage coordination, collaboration, and advocacy with the educational system to support the TFC Family Provider and Member in meeting treatment and educational goals.

J. TFC AGENCY PROVIDER SUPERVISION REQUIREMENTS

1. The AdSS shall ensure TFC Agency Providers meet the following supervision requirements:

   a. Clinical Supervision requires behavioral professional or higher, with a graduate degree in a human services field, and licensed with a minimum two years of experience:

      i. Clinical supervision of TFC Agency staff that directly supports TFC Family Providers is completed by a qualified clinical professional through regular direct clinical supervision.

      ii. An Agency may employ a shared supervision model where administrative supervision is conducted by a

non-clinical professional.

b. Administrative supervision requires a master's degree in a human services field and a minimum two years of experience.

c. Treatment planning for all TFC Family Providers is overseen by a qualified clinical professional as specified below:

i. TFC Agency Provider shall define and document minimum frequency of TFC Treatment Plan reviews which shall occur no less than once per quarter.

ii. The clinical supervisor shall have direct in-person or Telemedicine contact with the TFC Family Provider at least once per month.

iii. The clinical supervisor is part of the treatment team and shall be active in the case review and not solely independently reviewing the TFC Treatment Plan.

iv. The clinical supervisor shall participate in the CFT meetings on an as-needed basis depending on the

progress of the TFC Treatment Plan.

K. TFC FAMILY PROVIDER REQUIREMENTS

1. The AdSS shall ensure TFC Family Providers meet the following requirements:

    a. Have at least one year of experience as an active licensed foster home working directly with Members or professional experience working directly with Members that have behavioral health issues or developmental disabilities or both.

    b. Meet AHCCCS requirements of registration as an AHCCCS registered provider.

    c. Complete all training requirements and evaluations in preparation to provide TFC services effectively and safely to Members and their families, as well as any ongoing training requirements as identified by the TFC Agency Provider in collaboration with the CFT.

    d. Abide by all licensing regulations as outlined in applicable state and federal statutes for family foster parent licensing

requirements, therapeutic level of licensure.

e. Provide basic parenting functions consistent with food, clothing, shelter, educational support, medical needs, transportation, teaching daily living skills, social skills, developing community activities, and supporting cultural, spiritual, and religious beliefs.

f. Provide behavioral interventions associated with anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention, and other behavioral interventions as needed, that aid the Member in making progress on TFC Treatment Plan goals.

g. Provide a family environment with opportunities for:

i. Familial and social interactions and activities;

ii. Use of behavioral interventions;

iii. Development of age-appropriate living and self-sufficiency skills; and

iv. Integration into a family and community-based

setting.

h. Meet the individualized needs of the Member in their home as defined in the Member's TFC Treatment Plan.

i. Be available to care for the Member 24 hours per day, seven days a week, for the entire duration that the Member is receiving out-of-home treatment services, including times the Member is with respite caregivers.

j. Ensure that the Member's needs are met when the Member is in Respite Care with other TFC Family Providers.

k. Participate in planning processes such as CFTs, TFC discharge planning, and individualized education programs.

l. Keep the following documentation per requirements of the TFC Agency Provider:

i. Record behavioral health symptoms,

ii. Incident reports,

iii. Interventions utilized,

iv. Progress toward the TFC Treatment Plan goals, and

v. Discharge plan.

m. Assist the Member in maintaining contact with their family and natural supports.

n. Assist in meeting the Member's permanency planning or TFC discharge planning goals.

o. Advocate for the Member in order to achieve TFC Treatment Plan goals and to ensure timely access to educational, vocational, medical, or other indicated services.

p. Provide medication management consistent with AHCCCS guidelines for Members in out-of-home care.

q. Report allegations of abuse, neglect, and misconduct toward Members as required by state and federal law.

r. Maintain confidentiality as required by state and federal law.

2. The AdSS shall require any request to move a Member from placement prior to successful completion of the TFC Treatment Plan is made through the CFT, and written notice provided following contractual time frames, with the only exception being Immediate Jeopardy.

3. The AdSS shall require TFC Family Providers to follow the Crisis Plan and work to preserve the placement, including consultation with the CFT for consideration of additional in-home supports and services as appropriate and necessary to support the Member and family.

4. The AdSS shall require the TFC Family Providers to utilize the Crisis Plan and accept Agency Worker and supervisor support, including the use of respite, to maintain the placement until an emergency CFT meeting is convened, services implemented, and the placement is preserved.

5. If a TFC placement cannot be preserved, The AdSS shall ensure TFC Agency Providers support the Member and TFC Family Provider until a transition is identified.

SUPPLEMENTAL INFORMATION

1. For aftercare planning for DCS involved Members, the TFC Family Provider may be the discharge placement. In such cases where the TFC Family Provider is the discharge placement, DCS foster care rates, policies, and procedures apply. Licensing agencies shall coordinate these actions through the CFT and DCS as they are not governed by this Policy.

2. Ongoing appropriate and approved relationship and communication with the TFC family provider after discharge is encouraged. This is determined with Responsible Person approval and in the best interest of the Member.

3. The TFC Family Providers are licensed by DCS and do not require credentialing by the AdSS.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:49 MST)
Anthony Dekker, D.O.

320-X ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES

EFFECTIVE DATE: March 24, 2021

PURPOSE

This Policy establishes requirements for the provision of care and services to members in Adult Behavioral Health Therapeutic Homes (ABHTH).

DEFINITIONS

A. Adult Behavioral Health Therapeutic Home (ABHTH) **-** A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan, as appropriate.

B. Adult Recovery Team (ART) **-** A group of individuals that follows the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems. Working in collaboration and are actively involved in an individual's assessment, service planning, and service delivery.

C. Assessment **-** An analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101

D. Behavioral Health Professional (BHP) **–**

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091, or
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:

a. A psychiatric-mental health nursing certification, or

b. One year of experience providing behavioral health services.

E. Collaborating Health Care Institution (CHI) - A health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:

1. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and

2. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan. A.A.C. R9-10-101 (51.)

F. Designated Representative - An individual acting on behalf of the member with the written consent of the member or member's legal guardian. As used in this policy the Designated Representative is distinct and separate from the Health Care Decision Maker.

G. Health Care Decision Maker - An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§8-514.05, 36-3221, 36-3231 or 36-3281.

H. Provider - Any individual or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

I. Service Plan - A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

J. Treatment Plan - For the purpose of this Policy, Treatment Plan is used to describe a complete written description of all services to be provided by the ABHTH based on the intake assessments and Service Plan.

POLICY

ABHTH is a residential setting in the community that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Service Plan and/or Treatment Plan as appropriate.

Programmatic support is available to the ABHTH Providers 24 hours per day, seven days per week by the CHI. Care and services provided in an ABHTH are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board (Arizona State Plan for Medicaid). The Administrative Services Subcontractors (AdSS) shall refer to ACOM Policy 414 for information on timeframes and requirements regarding prior authorizations.

ABHTH Providers shall adhere to this Policy as well as procedure requirements as specified in A.A.C. R9-10-1801 et. Seq and the Arizona State Plan for Medicaid.

A. Criteria for Admission

The AdSS shall develop admission criteria for medical necessity, which at a minimum includes the below elements. The AdSS shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the AdSS website.

1. Criteria for Admission:
    a. The recommendation for ABHTH shall come through the ART process,
    b. Following an Assessment by a licensed BHP, the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for ABHTH,
    c. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per Assessment by a BHP:
        i. Cannot be reasonably expected to improve in response to a less intensive level of care, and
        ii. Does not require or meet clinical criteria for a higher level of care, or
        iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
    d. At time of admission to an ABHTH, in participation with the Health Care Decision Maker and all relevant stakeholders, there is a documented plan for discharge which includes:
        i. Tentative disposition/living arrangement identified, and
        ii. Recommendations for aftercare treatment based upon treatment goals.

B. Exclusionary Criteria

Admission to an ABHTH shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in an individual exhibiting primarily conduct disorder behaviors.

3. As a means of providing safe housing, shelter, supervision or permanent placement.

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/Health Care Decision Maker is unwilling to participate in the less restrictive alternative.

C. Expected Treatment Outcomes

1. Treatment outcomes shall align with:

   a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM Policy 100, and

   b. The member's individualized physical, behavioral, and developmentally appropriate needs.

2. Treatment goals for members placed in an ABHTH shall be:

   a. Specific to the member's behavioral health condition that warranted treatment,

   b. Measurable and achievable,

   c. Unable to be met in a less restrictive environment,

   d. Based on the member's unique needs,

   e. Inclusive of input from the member's family/Health Care Decision-Maker and Designated Representative's choices where applicable, and

   f. Supportive of the member's improved or sustained functioning and integration into the community.

3. Active treatment with the services available at this level of care can reasonably be expected to:

   a. Improve the member's condition in order to achieve discharge from the ABHTH at the earliest possible time, and

   b. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

D. Adult Behavioral Health Therapeutic Homes Treatment Planning

The ABHTH Treatment Plan shall be developed by the CHI in collaboration with the ABHTH Provider and the ART within the first 30 days of placement:

1. The Treatment Plan shall:
    a. Describe strategies to address ABHTH Provider needs and successful transition for the member to begin service with ABHTH Provider, including pre-service visits when appropriate,
    b. Compliment and not conflict with the ART Service Plan and other defined treatments, and shall also include reference to the member's:
        i. Current physical, emotional, behavioral health and developmental needs,
        ii. Current educational placement and needs,
        iii. Current medical treatment,
        iv. Current behavioral health treatment through other Providers, and
        v. Current prescribed medications.
    c. Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,
    d. Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ART Service Plan,
    e. Clearly identify responsible individuals from treatment team to implement each aspect of the ABHTH Treatment Plan and the timing of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH Treatment Plan,
    f. Include specific elements that build on the members' strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,
    g. Include specifics to coordinate with natural supports and informal networks as a part of treatment,
    h. Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,
    i. Be reviewed by the ABHTH Provider and CHI at every home visit,
    j. Be reviewed by the CHI Clinical Supervisor at each staffing,

k. Be revised as appropriate or quarterly at minimum, and

l. Include documentation of the ABHTH Treatment Plan which shall be kept by the ABHTH Provider and CHI.

2. The AdSS and providers shall ensure that members/Health Care Decision Maker and designated representatives receive a copy of the treatment plan and any updated treatment plans.

E. Criteria for Continued Stay

The AdSS shall develop medically necessary criteria for continued stay which, at a minimum, include the below elements. The AdSS shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the AdSS website.

1. All of the following shall be met:

a. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH,

b. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or appropriate self-care or self-regulation,

c. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community,

d. There is an expectation that continued treatment at the ABHTH shall improve the member's condition so that this type of service shall no longer be needed, and

e. The ART is meeting at least monthly to review progress and have revised the Treatment Plan and/or Service Plan to respond to any lack of progress.

F. Adult Behavioral Health Therapeutic Homes Discharge Planning

A comprehensive discharge plan shall be created during the development of the initial Treatment Plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:

1. Clinical status for discharge.

2. Follow-up treatment, crisis, and safety plan.

3. Coordination of care and transition planning are in process when appropriate.

G. Criteria for Discharge

The AdSS shall develop medical necessity criteria for discharge from an ABHTH setting which, at a minimum, includes the below elements. The AdSS shall submit discharge criteria to The Division for approval, as specified in Contract, and publish the approved criteria on the AdSS website.

1. Sufficient symptom or behavior relief is achieved as evidenced by completion of the ABHTH treatment goals.
2. The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care.
3. The member can participate in needed monitoring and follow-up services or a Provider is available to provide monitoring in a less restrictive level of care.
4. Appropriate services, Providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.
5. There is no evidence to indicate that continued treatment in an ABHTH would improve member's clinical outcome.
6. There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

H. AdSS Reporting Requirements

1. The AdSS shall monitor and report ABHTH bed utilization as specified in ACOM Policy 415, Attachment G or as requested by The Division or AHCCCS.
2. The AdSS shall report medical necessity criteria for admission, continued stay, and discharge for prior approval as specified in Contract.

320-Z MEMBERS ON CONDITIONAL RELEASE

EFFECTIVE DATE: August 30, 2023
REFERENCES: A.R.S. § 11-58; A.R.S. § 13- 3991; A.R.S. §§ 13-3994 through 13-4000; AMPM 320-Z.

PURPOSE

This Policy establishes requirements for the oversight of individuals who have been granted conditional release from the Arizona State Hospital (ASH) by the Superior Court. This policy applies to the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

2. "Conditional Release Plan" or "CRP" means a supervised treatment plan ordered by the Superior Court in conjunction with the State mental health facility and behavioral health community providers which specifies the conditions of a Member's release.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. AdSS RESPONSIBILITIES

1. The AdSS shall develop and implement policies and procedures to provide monitoring or other behavioral health and related services to Members on conditional release from the ASH consistent with the Conditional Release Plan (CRP) issued by the Superior Court.

2. The AdSS shall provide training to outpatient providers serving Members on conditional release and ensure outpatient providers demonstrate understanding of A.R.S. § 13-3991 and A.R.S. §§ 13-3994 through 13- 4000, duties of outpatient providers.

3. The AdSS shall establish relationships with the Superior Court and ASH to support streamlined communication and collaboration between the AdSS, the Division, outpatient

treatment team, ASH, and the Superior Court.

4. The AdSS shall develop and implement policies and procedures to proactively coordinate care for Members on conditional release awaiting admission to and discharge from ASH.

B. REPORTING REQUIREMENTS

The AdSS shall monitor and ensure the behavioral health outpatient providers complete the Conditional Release Monthly Monitoring Report for members on conditional release, and submit the form as directed by the Contractor Chart of Deliverables.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:02 PDT)
Anthony Dekker, D.O.

410 MATERNITY CARE SERVICES

REVISION DATE: 10/25/2023, 6/08/2022
EFFECTIVE DATE: August 5, 2021
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Exhibit F3, Contractor Chart of Deliverables

PURPOSE

This policy establishes the Administrative Services Subcontractors (AdSS) requirements for providing Maternity Care Services to Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Certified Nurse Midwife"or "CNM" means an individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health

care system that provides for medical consultation, collaborative management, or referral.

2. "High-Risk Pregnancy" means a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
3. "Licensed Midwife" or "LM" means an individual licensed by the Arizona Department of Health Services (ADHS) to provide Maternity Care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. Title 9, Chapter 16. This provider type does not include Certified Nurse Midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.
4. "Maternity Care" means identification of pregnancy, prenatal care, labor and delivery services, and postpartum care.

5. "Maternity Care Coordination" means the following Maternity Care related activities:
   a. Determining the member's medical or social needs through a risk assessment evaluation;
   b. Developing a plan of care designed to address those needs;
   c. Coordinating referrals of the member to appropriate service Providers and community resources;
   d. Monitoring referrals to ensure the services are received; and
   e. Revising the plan of care, as appropriate.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Perinatal Services" means medical services for the treatment and management of obstetrical patients and neonates as specified in A.A.C. R9-10-201.
8. "Postpartum" means the period beginning on the last day of pregnancy and extends through the end of the month in which

the 60-day period follows the end of pregnancy. For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in Maternity Care quality improvement may utilize different criteria for the postpartum period.

9. “Postpartum Care” means care provided during the period beginning the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy.

10. “Practitioner” means certified nurse practitioners in midwifery, physician assistants, and other nurse practitioners.

11. "Preconception Counseling" means the provision of assistance and guidance aimed at identifying or reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventive care visit and does not include genetic testing.
12. "Prenatal Care" means the health care provided during pregnancy and is composed of three major components:
    a. Early and continuous risk assessment;
    b. Health education and promotion, including written Member educational outreach materials; and
    c. Medical monitoring, intervention, and follow-up.

13. "Providers" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
14. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
15. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.
16. "Work Plan" means a document that identifies goals and methodology for improvement utilizing the Plan-Do-Study-Act

(PDSA) method, and monitoring efforts related to the program requirements.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall cover Maternity Care Services for all eligible, enrolled ALTCS Members of childbearing age. Maternity Care services include:
    a. Medically necessary preconception counseling;
    b. Identification of pregnancy;
    c. Medically necessary education and written Member educational outreach materials;
    d. Treatment of pregnancy-related conditions;
    e. Prenatal services for the care of pregnancy;
    f. Labor and delivery services;
    g. Postpartum care;
    h. Outreach;
    i. Family Planning Services and Supplies; and
    j. Related services such as:

2. The AdSS shall ensure all Maternity Care Services to be delivered by qualified providers and in compliance with the most current ACOG standards for obstetrical and gynecological services.
3. The AdSS shall allow LM's to provide Prenatal Care, labor, delivery, and Postpartum Care services within their scope of practice, while adhering to AHCCCS risk-status consultation and referral requirements.
4. The AdSS shall ensure all cesarean sections include medical documentation surrounding medical necessity.
    a. The AdSS shall ensure all inductions and cesarean sections done prior to 39 weeks shall follow the ACOG guidelines.
    b. The AdSS shall ensure any inductions performed prior to 39 weeks or cesareans sections performed at any time that are found not to be medically necessary are not eligible for payment.
5. The AdSS shall cover related services such as outreach and Family Planning Services and Supplies, whenever appropriate,

based on the Member's current eligibility and enrollment as specified in AMPM 420.

B. AdSS REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

1. The AdSS shall establish and operate a Maternity Care program with program goals directed at achieving optimal birth outcomes. The following are the minimum requirements of the Maternity Care program:
    a. Sufficient numbers of qualified local personnel to meet the requirements of the Maternity Care program for eligible enrolled Members and achieve contractual compliance;
    b. Provision of written Member educational outreach utilizing mechanisms for Member dissemination to meet the following requirements as specified in AMPM Exhibit 400-3:
        i. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation;
        ii. Healthy pregnancy measures addressing at a minimum:

a) Nutrition;

b) Sexually transmitted infections;

c) HIV testing;

d) Alcohol, opioids, and substance use and other risky behaviors;

e) Measures to reduce risks for low or very low infant birth weight; and

f) Recognizing active labor.

iii. Dangers of lead exposure to birthing mother and baby during pregnancy and how to prevent exposure;

iv. Postpartum depression;

v. Postpartum services available and the importance of timely prenatal and postpartum care;

vi. Provision of information regarding the opportunity to change health plans to ensure continuity of prenatal care to newly assigned pregnant women and those

currently under the care of an out-of-network provider;

vii. Postpartum warning signs that require contacting a provider;

viii. Maternity Care practices that are supportive of breastfeeding, and breastfeeding information;

ix. Safe sleep and ways to reduce Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) risk;

x. Interconception spacing recommendations and family planning options, including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) as specified in AMPM Policy 420;

xi. Ways to minimize interventions during labor and birth as recommended by ACOG;

xii. Support resources and programs such as:

a) Arizona Supplemental Nutrition Program for Women, Infants, and Children (WIC),

b) Strong Families AZ home visitation programs,

c) Arizona Department of Health Services breastfeeding hotline,

d) Early Head Start or Head Start, and

e) Birth to Five Helpline.

xiii. Information on how to obtain pregnancy related services and assistance with scheduling appointments;

xiv. A statement that there is no copayment or other charge for pregnancy-related services as specified in ACOM Policy 431;

xv. A statement that assistance with medically necessary transportation is available to obtain pregnancy related services as specified in AMPM Policy 310-BB; and

xvi. Other AdSS selected topics.

c. Implementation of written protocols to inform pregnant women and Maternity Care Providers of voluntary prenatal

HIV or AIDS testing, and the availability of medical counseling and treatment, as well as the benefits of treatment, if the test is positive.

i. The AdSS shall include information to encourage pregnant women to be tested and provide instructions on where testing is available as specified in AMPM Exhibit 400-3.

ii. The AdSS shall report the number of pregnant women who are HIV or AIDS positive, as specified in contract, see AMPM 410 Attachment A.

d. Conducting outreach and educational activities to identify currently enrolled Members who are pregnant and enter them into prenatal care as soon as possible.

i. The AdSS shall ensure programs include protocols for service providers to notify the AdSS promptly when Members have tested positive for pregnancy.

ii. The AdSS shall notify the Division at maternalandchildhealth@azdes.gov and

dddcctreferral@azdes.gov when Members have tested positive for pregnancy.

iii. The AdSS shall have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant women. If activities prove to be ineffective, the AdSS shall implement different activities.

e. Participation in community and quality initiatives, efforts to reduce maternal mortality and morbidity and address health disparities in maternal and infant health within the communities served by the AdSS.

f. Designation of a Maternity Care provider for each Member who is pregnant for the duration of her pregnancy and postpartum care.

i. The AdSS shall allow for freedom of choice, while not compromising the continuity of care.

ii. The AdSS shall allow Members who transition to a different AdSS or become newly enrolled with an

AdSS during their third trimester shall be allowed to complete Maternity Care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

g. Written new Member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool from ACOG covering psychosocial, nutritional, medical and educational factors.

h. Mandatory Maternity Care coordination services for all pregnant women to include:

   i. Identified barriers with navigating the health care system, evident by missed visits,

   ii. Difficulties with transportation, or

   iii. Other perceived barriers.

i. Demonstration of an established process for assuring:

   i. Network Physicians, Practitioners, and LMs adhere to the highest standards of care, including the use of a

standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults or referrals for increased-risk or high-risk pregnancies using ACOG criteria,

ii. Maternity Care Providers educate Members about healthy behaviors during the perinatal period, including:

a) The importance of proper nutrition;

b) Dangers of lead exposure to birthing mother and child;

c) Tobacco cessation;

d) Avoidance of alcohol and other harmful substances, including illegal drugs;

e) Prescription opioid use;

f) Screening for sexually transmitted infections;

g) The physiology of pregnancy;

h) The process of labor and delivery;

i) Breast-feeding;

j) Other infant care information;

k) Interconception health and spacing;

l) Family planning services and supplies, including IPLARC;

m) Postpartum follow-up; and

n) Other education as needed for optimal outcomes.

iii. Members are referred for the following support services:

a) Special Supplemental Nutrition Program for WIC,

b) Home visitation programs for pregnant women and their children, and

c) Other community-based resources to support healthy pregnancy outcomes.

iv. Maternity Care Providers maintain a complete medical record, documenting all aspects of maternity care;

v. Pregnant women have been referred to and are receiving appropriate care from a qualified physician; and

vi. Postpartum services are provided to Members within the time frame that aligns with performance measures as specified in AMPM 970.

j. Mandatory provision of initial prenatal care appointments within the established timeframes and as specified in ACOM Policy 417. The established timeframes are as follows:

i. First trimester - within 14 calendar days of a request for an appointment,

ii. Second trimester - within seven calendar days of a request for an appointment,

iii. Third trimester - within three business days of a request for an appointment, or

iv. High risk pregnancies as expeditiously as the Member's health condition requires and no later than

three business days of identification of high risk by the AdSS, Division or Maternity Care provider or immediately, if an emergency exists.

k. Verification of Members who are pregnant, to ensure that the above timeframes are met, and to effectively monitor Members are seen in accordance with those timeframes.

l. Monitoring and evaluation of infants born with low or very low birth weight, and implementation of interventions to decrease the incidence of infants born with low or very low birth weight.

m. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, and implementation of interventions to decrease occurrence, including addressing variations in provider cesarean section rates for first-time pregnant women with a term, singleton baby in a vertex or head down position.

n. Monitoring and evaluation of maternal mortality and implementation of interventions to decrease the

occurrence of pregnancy-related mortality and health disparities in both the prenatal and postpartum period.

o. Monitoring and evaluation to ensure that Maternity Care practices that support breastfeeding success are being utilized per ACOG and American Academy of Pediatrics (AAP) guidance.

p. Identification of postpartum depression with the required use of any norm-criterion referenced validated screening tool to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the Maternity Care provider or subsequent referral for behavioral health services, if clinically indicated.

q. Process for monitoring provider compliance for perinatal or postpartum depression screenings conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

r. Return visits scheduled in accordance with ACOG standards. A process shall be in place to monitor these appointments and ensure timeliness.

s. Inclusion of the first and last prenatal care dates of service and the number of obstetrical visits that the Member had with the provider on claim forms to AHCCCS regardless of the payment methodology.

t. Continued payment of obstetrical claims upon receipt of claim after delivery and shall not postpone payment to include the Postpartum visit. The AdSS shall require a separate zero-dollar claim for the postpartum visit.

u. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB.

v. Monitoring and evaluation of Postpartum activities and implementation of interventions to improve the utilization rate where needs are identified.

w. Participation in reviews of the Maternity Care Services program conducted by the Division as requested, including provider visits and audits.

C. MATERNITY CARE PROVIDER REQUIREMENTS

1. The AdSS shall ensure Providers adhere to the following Maternity Care requirements:
   a. Maternity Care Providers shall follow the ACOG standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.
   b. LMs, if included in the AdSS provider network, adhere to the requirements contained within AHCCCS policy, procedures, and contracts.
2. The AdSS shall require all Maternity Care Providers ensure:
   a. Division Members have been referred to a qualified provider and are receiving appropriate care;
   b. All pregnant women are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester. For those Members receiving opioids,

appropriate intervention and counseling shall be provided, including referral of Members for behavioral health services, as indicated for Substance Use Disorder (SUD) assessment and treatment;

c. All pregnant women are screened for Sexually Transmitted Infections (STI), including syphilis during:
   i. First prenatal visit,
   ii. Third trimester, and
   iii. Time of delivery.

d. Members are educated about healthy behaviors during pregnancy, including:
   i. The importance of proper nutrition;
   ii. Dangers of lead exposure to birthing mother and child;
   iii. Tobacco cessation;
   iv. Avoidance of alcohol and other harmful substances, including illegal drugs;
   v. Prescription opioid use;

vi. Screening for sexually transmitted infections;

vii. The physiology of pregnancy;

viii. The process of labor and delivery;

ix. Breastfeeding;

x. Other infant care information;

xi. Interconception health and spacing;

xii. Family Planning Services and Supplies, including IPLARC;

xiii. Postpartum follow-up; and

xiv. Other education as needed for optimal outcomes.

e. All pregnant women receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed.

f. Providers utilize evidence based practices per ACOG and AAP to increase the initiation and duration of breastfeeding.

g. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.

i. Postpartum depression screening is not a separately reimbursable service as it is considered part of the global service.

ii. Providers shall refer to any norm-referenced validated screening tool to assist the provider in assessing the postpartum needs of the birthing mother regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the AdSS for behavioral health services, if clinically indicated.

h. Member medical records are appropriately maintained and document all aspects of the Maternity Care provided.

i. Members are referred to the following for support services to support healthy pregnancy and infant outcomes:

   a. Special Supplemental Nutrition Program for WIC,

   b. Strong Families AZ home visiting programs,

   c. Arizona Department of Health Services breastfeeding hotline,

   d. Birth to Five Helpline, and

   e. Other community-based resources.

j. Members are notified that, in the event they lose eligibility for services, they may contact Arizona Department of Health Services (ADHS) Hotline for referrals to low-cost or no-cost services.

k. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the Member had with the provider, are recorded on all claim forms submitted to the AdSS regardless of the primary payer or payment methodology used, and

l. Postpartum services as clinically indicated are provided to Members within the postpartum period and adhere to current AHCCCS minimum performance measures as specified in Contract.

3. The AdSS shall ensure Maternity Care Providers utilize a separate zero-dollar claim for the postpartum visit.

D. PREGNANCY TERMINATION

1. The AdSS shall cover pregnancy termination if one of the following criteria is present:

   a. The pregnant woman suffers from the following, which places the Member in danger of death unless the pregnancy is terminated, as certified by a physician:

      i. A physical disorder;

      ii. Physical injury; or

      iii. Physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself.

   b. The pregnancy is a result of incest;

c. The pregnancy is a result of rape; or

d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant woman by:

i. Creating a serious physical or behavioral health problem for the pregnant woman;

ii. Seriously impairing a bodily function of the pregnant woman;

iii. Causing dysfunction of a bodily organ or part of the pregnant woman;

iv. Exacerbating a health problem of the pregnant woman; or

v. Preventing the pregnant woman from obtaining treatment for a health problem.

2. The AdSS shall ensure the following requirements regarding Prior Authorization (PA) are met except in cases of medical emergencies:
   a. The Provider obtains a prior authorization for all covered pregnancy terminations from the AdSS Medical Director;
   b. The attending physician submits a request for review of the pregnancy termination qualifying diagnosis and condition to the AdSS Medical Director or designee for enrolled pregnant women with clinical information that supports the medical necessity or other criteria met for the procedure;
   c. The AdSS Medical Director reviews the prior authorization request, as specified in AMPM 410 Attachments C and D, and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination; and
   d. The attending physician submits all documentation of medical necessity to the AdSS, within two working days of

the date on which the pregnancy termination procedure was performed, in cases of medical emergencies.

3. The AdSS shall ensure that any decision to deny a service authorization request or to authorize a service amount is made by a Healthcare Professional who has appropriate clinical expertise in treating the Member's condition or disease.
4. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
   a. Hysterectomy;
   b. Sterilization; or
   c. Termination of pregnancy.
5. The AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven business days, for review and response for standard service authorization requests, and two business days for expedited service authorization requests.

6. The AdSs shall ensure expedited requests are clearly labeled as expedited.
7. The AdSS may request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.
8. The AdSS shall ensure:
    a. A written consent obtained by the provider and filed in the Member's medical record for a pregnancy termination;
    b. If the pregnant woman is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. § 14-5101, a dated signature of the responsible person indicating approval of the pregnancy termination procedure is required;
    c. When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed.

d. The documentation requirement above in subsection (c) is waived if the treating physician certifies that, in his or her professional opinion, the Member was unable, for physical or psychological reasons, to comply with the requirement;

e. Providers follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy, current standards of care per ACOG shall be utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected;

f. Pregnancy termination by surgery or standard of care is recommended in cases when medications are used and fail to induce termination of the pregnancy.

g. When medications are administered to induce termination of the pregnancy, the following documentation is also required:

   i. Name of medication(s) used,

   ii. Duration of pregnancy in days,

   iii. The date medication was given,

iv. The date any additional medications were given, and

v. Documentation that pregnancy termination occurred.

8. The AdSS shall submit the following reporting requirements to AHCCCS and the Division:

a. AHCCCS Certificate of Necessity for Pregnancy Termination and AHCCCS Verification of Diagnosis by AdSS for Pregnancy Termination Requests AMPM 410 Attachments C and D as specified in Contract,

b. Pregnancy Termination Report and the required documentation as listed in AMPM 410 Attachment E, as specified in Contract.

9. The AdSS shall ensure procedures are developed to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

E. REQUIREMENTS FOR THE MATERNITY AND FAMILY PLANNING SERVICES ANNUAL PLAN

1. Each AdSS shall have a written Maternity and Family Planning Services Annual Plan that includes the following requirements:

a. Addresses minimum AdSS requirements, as well as the objectives of the AdSS' program that are focused on achieving Division and AHCCCS requirements;

b. Incorporates monitoring and evaluation activities as specified in AMPM Exhibit 400-2A Maternity and Family Planning Services Annual Plan Checklist;

c. The Maternity and Family Planning Services Annual Plan shall be submitted to the Division Health Care Services Unit through the Division Compliance Unit;

d. The Maternity and Family Planning Services Annual Plan shall contain, at a minimum, the following:

    i. Maternity and Family Planning Services Care Plan which provides a written, narrative description of all planned activities to address the AdSS minimum requirements for Maternity Care and Family Planning Services and Supplies, including participation in community and quality initiatives within the communities served by the AdSS.

a) The narrative description shall also include AdSS activities to identify Member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

ii. Maternity and Family Planning Services Work Plan Evaluation which provides an evaluation and assessment of the previous year's Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

iii. Maternity and Family Planning Services Work Plan that includes specific measurable objectives.

a) These objectives shall be based on Division and AHCCCS established minimum performance standards.

b) In cases where Division and AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue

the AdSS improvement efforts shall be used including:

1) National Committee on Quality Assurance (NCQA),
2) CMS Core Measures, and
3) Healthy People 2030 standards.

c) The AdSS may also develop additional specific measurable goals and objectives aimed at enhancing the Maternity Program when Division and AHCCCS Minimum Performance Standards have been met.

d) Strategies and specific measurable interventions specific to Division Members to accomplish objectives including:

1) Member outreach,
2) Provider education, and

3) Provider compliance with mandatory components of the Maternity and Family Planning Services program.

e) Targeted implementation and completion dates of Work Plan activities.

f) Assigned local staff position(s) responsible and accountable for meeting each established goal and objective specific to the Division Members.

g) Identification and implementation of new interventions and continuation of or modification to existing interventions specific to Division Members, based on analysis of the previous year's Work Plan evaluation.

h) Relevant policies and procedures, referenced in the Maternity and Family Planning Services Annual Plan, submitted as separate attachments.

F. ADDITIONAL RELATED SERVICES

1. The AdSS shall cover circumcision for males as follows:
    a. Circumcision for males, only when it is determined to be medically necessary, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
    b. Routine circumcision for newborn males is not a covered service; and
    c. The procedure requires Prior Authorization (PA) if required by the newborn's Health Plan.
2. The AdSS shall cover home uterine monitoring technology when determined to be medically necessary as follows:.
    a. Covered for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.
    b. If the member has one or more of the following conditions, home uterine monitoring may be considered for:
        i. Multiple gestation, particularly triplets or quadruplets;

ii. Previous obstetrical history of one or more births before 35 weeks gestation;

iii. For a pregnant woman ready to be discharged home after hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis.

c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

3. The AdSS shall cover labor and delivery services provided in Free Standing Birthing Centers.

a. For members who meet medical criteria specified in this policy when labor and delivery services are provided by Maternity Care Providers.

b. Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a Free Standing Birthing Center.

c. Risk status shall be determined by the attending physician or Certified Nurse Midwife (CNM), using the standardized ACOG assessment tools for high-risk pregnancies. In any area of the risk assessment where standards conflict, the most stringent will apply.

d. The age of the member is considered in the risk status evaluation as Members younger than
18 years of age are generally considered high risk.

e. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in Free Standing Birthing Centers.

4. The AdSS shall cover labor and delivery services provided in a home setting by the Member's maternity provider.

a. For members who meet medical criteria, AHCCCS covers labor and delivery services provided in the home by:

i. Maternity provider physicians,

ii. CNMs, or

iii. LMs.

b. Only AHCCCS members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver in the Member's home.

c. Risk status shall initially be determined at the time of the first visit, and each trimester thereafter, by the Member's Maternity Care provider, using the current standardized ACOG assessment criteria and protocols for High-Risk Pregnancies.

d. A risk assessment shall be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

e. Physicians and CNMs who render home labor and delivery services shall have admitting privileges at an acute care hospital in close proximity to the site where the services

are provided in the event of complications during labor and delivery.

f. For each anticipated home labor and delivery, LMs who render home labor and delivery services shall have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided.

g. Referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, shall be included in the plan of action.

h. Upon delivery of the newborn, the physician, CNM or LM is responsible for conducting the following newborn examination procedures, including:

i. A mandatory Bloodspot Newborn Screening Panel

ii. Referral of the infant to an appropriate health care provider for a mandatory hearing screening,

iii. A second mandatory Bloodspot Newborn Screening Panel, and

iv. Second newborn hearing screening.

i. The Maternity Care provider shall notify the birthing mother's AdSS no later than three days after the birth in order to enroll the newborn with AHCCCS.

5. The AdSS shall cover licensed midwife services by LMs for Members, if LMs are included in the AdSS' provider network.

a. The AdSS shall ensure Members who choose to receive maternity services from this provider type shall meet eligibility and medical criteria specified in this policy.

b. The AdSS shall ensure risk status initially be determined at the time of the first visit, and each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from ACOG.

c. The AdSS shall ensure an ACOG risk assessment is conducted when a new presenting complication or concern

arises to ensure proper care and referral to a qualified provider, if necessary.

d. The AdSS shall ensure documentation certifying the risk status of the Member's pregnancy is submitted to the AdSS, before providing midwife services.

e. The AdSS shall ensure a consent form signed and dated by the Member shall be submitted, indicating that the Member has been informed and understands the scope of services that shall be provided by the LM, including the risks to a home delivery.

f. The AdSS shall ensure Members are immediately referred within the provider network of the Member's AdSS for Maternity Care Services who:

   i. Are initially determined to have a high-risk pregnancy, or

   ii. Members whose physical condition changes to high-risk during the course of pregnancy.

g. The AdSS shall ensure Labor and delivery services provided by a LM are not provided in a hospital.

i. LMs shall have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise.

ii. This plan of action shall be submitted to the AdSS Medical Director or designee.

h. The AdSS shall ensure the LM notifies the birthing mother's AdSS of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

Signature of Chief Medical Officer: Anthony Dekker (Oct 21, 2023 09:06 PDT)
Anthony Dekker, D.O.

411 WOMEN'S PREVENTIVE CARE SERVICES

REVISION DATE: 6/08/2022
EFFECTIVE DATE: May 27, 2016
REFERENCES: AMPM Exhibit 400-3, AMPM Policy 420, AMPM Policy 310-BB, AMPM Chapter 300, ACOM Policy 431, ACOM Policy 406. ACOM Policy 405.

PURPOSE

This policy establishes AdSS requirements for well-woman preventive care visits as a covered benefit for women to obtain the recommended preventive services, including Preconception Counseling.

DEFINITIONS

1. "Clinical Breast Exam" means a physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

2. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member's lifestyle and provision of indicated supplies.

3. "Human Papillomavirus (HPV)" means a sexually transmitted infection for which a series of immunizations are available for both males and females.

4. "Mammogram" means an x-ray of the breasts used to look for early signs of breast cancer.

5. "Preconception Counseling" means the purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy by identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. Preconception Counseling is considered included in the well-woman preventive care visit.

POLICY

A. A well-woman preventive care visit is covered on an annual basis.

B. The AdSS shall develop policies and procedures to monitor, evaluate, and improve women's participation in preventive care services. Contractors shall:

1. Inform all participating primary care providers (PCPs), including Obstetrician/Gynecologist (OB/GYN) providers of the availability of women's preventive care services, detailing the covered services included as part of the well-woman preventive care visit, as outlined in this policy.

2. Develop and implement a process for monitoring compliance with well-woman preventive care services provider requirements.

3. Develop, implement, and maintain a process to inform members about women's preventive health services as specified in this policy, in AMPM Exhibit 400-3, and that align with the requirements in ACOM Policy 406. This information shall be provided as specified in ACOM Policy 405.

    a. This information shall include:

        i. The benefits of preventive health care,

        ii. A complete description of the services available as described in the provider requirements,

        iii. A statement that provides assistance with information on how to obtain medically necessary

transportation as specified in AMPM Policy 310-BB including scheduling appointments to obtain well-woman preventive care services, and

iv. A statement that there is no copayment or other charge for women's preventive care visit as specified in ACOM Policy 431.

C. Provider requirements for Well-woman preventive care services include at a minimum the following covered services at each service:

1. A physical exam (Well Exam) that assesses overall health,
2. Clinical Breast Exam,
3. Pelvic exam (as necessary, according to current recommendations and best standards of practice),
4. Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors as specified in AMPM Chapter 300.
5. Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addresses at a minimum the following:

a. Proper nutrition,

b. Physical activity,

c. Elevated BMI indicative of obesity,

d. Tobacco/substance use, abuse, and/or dependency,

e. Depression screening,

f. Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems,

g. Sexually transmitted infections,

h. Human Immunodeficiency Virus (HIV),

i. Family Planning Services and Supplies, (refer to AMPM Policy 420),

j. Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:

i. Reproductive history and sexual practices,

ii. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake,

iii. Physical activity or exercise,

iv. Oral health care,

v. Chronic disease management,

vi. Emotional wellness,

vii. Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and

viii. Recommended intervals between pregnancies, and

ix. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified. Screenings as specified in AMPM Chapter 300 and AMPM Policy 430. Genetic screening and testing are not covered, except as specified in AMPM Policy 310-II.

D. Well-Woman Preventive Care Service Standards

1. Immunizations:

   a. AHCCCS covers the HPV vaccine for members, as specified in AMPM Policy 310-M.

   b. Providers shall coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Providers shall enroll and re-enroll annually with the VFC program, as specified in AMPM Policy 430.

   c. Immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule as specified on the CDC website https://www.cdc.gov/vaccines/schedules/index.html, and

   d. Contractors shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 17:25 PDT)

Anthony Dekker, D.O.

420 FAMILY PLANNING SERVICES AND SUPPLIES

REVISION DATE: 1/10/2024, 9/6/2023, 6/8/2022
REVIEW DATE: 9/14/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36.2904(L), 42 CFR 50.203 and 204, AMPM 420, AMPM 420 Attachment A and B

PURPOSE

This policy establishes requirements and describes covered services regarding Family Planning Services and Supplies for the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Business Days" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Family Planning Provider" means individuals who are involved in providing Family Planning services to individuals and may include physicians, physician assistants, nurse practitioners, nurse midwives, midwives, nursing staff and health educators.

3. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a healthcare provider to allow Members to make informed decisions about the specific Family Planning methods available that align with the Member's lifestyle and provision of indicated supplies. Family Planning Services and Supplies include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy.
4. "Hysterosalpingogram" means an X-ray procedure used to confirm sterility (occlusion of the fallopian tubes).
5. Immediate Postpartum Long-Acting Reversible Contraceptives" or "IPLARC" means immediate postpartum placement of reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.
6. "Long-Acting Reversible Contraceptives" or "LARC" means reversible methods for Family Planning that provide effective

contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.

7. "Maternity Care Provider" means the following provider types who may provide maternity care when it is within their training and scope of practice:
   a. Arizona licensed allopathic or osteopathic physicians who are obstetricians or general practice or family practice providers who provide maternity care services,
   b. Physician Assistant,
   c. Nurse Practitioners,
   d. Certified Nurse Midwives, and
   e. Licensed Midwives.
8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
9. "Reproductive Age" means Division Members, regardless of gender, from 12 to 55 years of age.

10. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall cover Family Planning Services and Supplies when provided by the appropriate Family Planning Providers or Maternity Care Providers for Members, regardless of gender, who voluntarily choose to delay or prevent pregnancy.
2. The AdSS shall ensure that services provided are within each provider's training and scope of practice.
3. The AdSS shall cover the provision of accurate information and counseling to allow Members to make informed decisions about specific Family Planning methods available.

4. The AdSS shall ensure Members enrolled with a health plan maintain the option to choose Family Planning Services and Supplies from any appropriate provider regardless of whether or not the Family Planning Service Providers are network providers.
5. The AdSS shall allow pregnant or postpartum Members whose AHCCCS eligibility continues, remain with their assigned maternity provider, or may select another provider for Family Planning Services and Supplies.

B. SECOND LEVEL REVIEW

1. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
   a. Hysterectomy,
   b. Sterilization, or
   c. Termination of pregnancy.
2. The AdSS shall submit a request to the Division for prior authorization with clinical documentation that supports medical necessity for the required service and includes the following:

a. Medical records related to the request;

b. AHCCCS Certificate of Necessity for Pregnancy Termination, if applicable;

c. Verification of Diagnosis by Contractor for a Pregnancy Termination, if applicable; and

d. Consent to Sterilization, if applicable.

3. The AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven Business Days, for review and response for standard service authorization requests.

4. The AdSS shall submit expedited service authorization requests within two Business Days and clearly label these requests as expedited.

5. The AdSS shall request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization prior to approval or denial being communicated to the Member or provider.

6. The AdSS shall allow the Division to make the final decision on prior authorization requests elevated for Second Level Review.

C. AMOUNT, DURATION, AND SCOPE

1. The AdSS shall ensure that Members whose eligibility continues maintain the option to remain with their assigned maternity provider or select another provider for Family Planning Services and Supplies.
2. The AdSS shall cover the following Family Planning Services and Supplies for Members:
    a. Contraceptive counseling, medication, or supplies:
        i. Oral and injectable contraceptives;
        ii. LARC;
        iii. IPLARC;
        iv. Diaphragms;
        v. Condoms;
        vi. Foams; and
        vii. Suppositories.

b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to Family Planning;

c. Treatment of complications resulting from contraceptive use, including emergency treatment;

d. Natural Family Planning education or referral to other qualified health professionals;

e. Post-coital emergency oral contraception, excluding Mifepristone (Mifeprex or RU-486) within 72 hours after unprotected sexual intercourse; and

f. Sterilization by Hysteroscopic Tubal Sterilization or Vasectomy.

    i. The AdSS shall ensure the provider counsels and recommends the Member continue another form of birth control to prevent pregnancy for up to three months following the Hysteroscopic Tubal Sterilization or Vasectomy.

ii. The AdSS shall ensure the provider performs a Hysterosalpingogram or sperm count according to the current standard of care for the sterilization procedure to confirm the Member is sterile following the Hysteroscopic Tubal Sterilization or Vasectomy.

3. The AdSS shall cover the following Family Planning Services:
   a. Pregnancy screening;
   b. Pharmaceuticals when associated with medical conditions related to Family Planning or other medical conditions;
   c. Screening and treatment for Sexually Transmitted Infections (STI) for Members, regardless of gender;
   d. Sterilization, regardless of Member's gender, when the requirements specified in this policy, for sterilization services are met; and
   e. Pregnancy termination only as specified in AMPM Policy 410.
4. The AdSS shall not cover the following for the purpose of Family Planning Services and Supplies:

a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility;

b. Pregnancy termination counseling;

c. Pregnancy terminations, except as specified in AMPM Policy 410; and

d. Hysterectomies for the purpose of sterilization.

D. AdSS REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES AND SUPPLIES

1. The AdSS shall plan and implement an outreach program to notify Members of Reproductive Age, regardless of gender, of the specific covered Family Planning Services and Supplies available and how to request them.
2. The AdSS shall ensure the following Family Planning Services and Supplies information are provided to Members:
   a. A complete description of available covered services;
   b. Information advising how to request or obtain these services;
   c. Information that assistance with scheduling is available;

d. A statement that there is no copayment or other charge for Family Planning Services and Supplies as specified in ACOM Policy 431; and

e. A statement that medically necessary transportation services as specified in AMPM 310-BB are available.

3. The AdSS shall ensure policies and procedures are in place to ensure Family Planning Providers are educated regarding covered and non-covered services, Family Planning Services and Supplies, including LARC and IPLARC options.

4. The AdSS shall ensure Family Planning Services and Supplies are:

a. Provided in a manner free from coercion or behavioral or mental pressure;

b. Available and easily accessible to Members;

c. Provided in a manner which assures continuity and confidentiality;

d. Provided by, or under the direction of, a qualified physician or practitioner; and

e. Documented in the medical record that each Member of Reproductive Age was notified verbally or in writing of the availability of Family Planning Services and Supplies.

5. The AdSS shall ensure providers incorporate medical audits for Family Planning Services and Supplies within Quality Management activities to determine conformity with acceptable medical standards.
6. The AdSS shall establish quality or utilization management indicators to effectively measure and monitor the utilization of Family Planning Services.
7. The AdSS shall have written practice guidelines that detail specific procedures for the provision of LARC or IPLARC and are written in accordance with acceptable medical standards.
8. The AdSS shall ensure that the Family Planning or Maternity Care Provider has provided proper counseling to the eligible Member, prior to insertion of intrauterine and subdermal implantable contraceptives to increase the Member's success with the device according to the Member's reproductive goals.

E. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING SERVICES AND SUPPLIES AND AdSS REPORTING REQUIREMENTS

1. The AdSS shall establish processes to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions.
2. The AdSS shall ensure the following minimum requirements are met for notification of covered Family Planning Services and Supplies:
    a. Members of Reproductive Age be notified either directly or through the parent or Health Care Decision Maker, whichever is most appropriate, of the specific covered Family Planning Services and Supplies available to them, and a plan to provide those services and supplies to Members who request them by:
        i. Provisions for written notification, other than the Member handbook,
        ii. Member newsletter, and

iii. Verbal notification during a Member's visit with the PCP.

b. Family Planning notification is sent by the end of the second trimester for pregnant Members and include information on LARC or IPLARC;

c. The AdSS shall conform to confidentiality requirements as specified in 45 C.F.R. 164.522(b) (i and ii);

d. Communications and correspondence shall be approved by the Division;

e. Distribution at least once per year and are completed by November 1st. For Members who enroll with the AdSS after November 1st, notification is sent at the time of enrollment;

f. Notification of all covered Family Planning Services and instructions given to Members regarding how to access these services;

g. Written notification at reading level and easily understood as specified in ACOM 404.

h. Notification in accordance with cultural competency requirements as specified in ACOM Policy 405;

i. The AdSS shall monitor compliance to ensure the Maternity Care Providers verbally notify Members of the availability of Family Planning Services during office visits;

j. The AdSS shall report all Members under 21 years of age, undergoing a procedure that renders the Member sterilized, using the AHCCCS Sterilization Reporting Form, AMPM 420 Attachment B and submitting documentation supporting the medical necessity for the procedure.

F. STERILIZATION

1. The AdSS shall ensure the following criteria are met for the sterilization of a Member to occur:

   a. The Member is at least 21 years of age at the time the consent is signed, using AHCCCS Consent to Sterilization AMPM 420 Attachment A;

   b. The Member has not been declared mentally incompetent;

c. Voluntary consent was obtained by the Member or Responsible Person without coercion;

d. 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

i. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization.

ii. Consent is given at least 30 days before the expected date of delivery in the case of premature delivery.

2. The AdSS shall ensure any Member requesting sterilization signs the AHCCCS Consent to Sterilization form with a witness present when the consent is obtained as specified in AMPM 420.

3. The AdSS shall ensure suitable arrangements are made to ensure the information in the consent form is effectively

communicated to Members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual or auditory limitations as specified in ACOM 404 and ACOM 405.

4. The AdSS shall ensure the Member receives a copy of the consent form and offered factual information prior to signing the consent form that includes all of the following:
   a. Consent form requirements as specified in 42 CFR 441.250;
   b. Answers to questions asked regarding the specific procedure to be performed;
   c. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care or loss of federally funded program benefits;
   d. Advice that the sterilization procedure is considered to be irreversible;
   e. A thorough explanation of the specific sterilization procedure to be performed;

f. A description of available alternative methods;

g. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used;

h. A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and

i. Notification that sterilization cannot be performed for at least 30 days post consent.

5. The AdSS shall ensure sterilization consents are not obtained when a Member is:

a. In labor or childbirth;

b. Seeking to obtain, or is obtaining, a pregnancy termination; or

c. Under the influence of alcohol or other substances that affect that Member’s state of awareness.

SUPPLEMENTAL INFORMATION

Sterilization

Hysteroscopic tubal sterilization and other sterilization methods are not immediately effective upon completion. It is expected that the procedure will be an effective sterilization procedure three (3) months following completion. Therefore, during the first (3) three months, the Member shall continue using another form of birth control to prevent pregnancy.

At the end of the 3 months, it is expected that a Hysterosalpingogram or sperm count will be performed confirming that the Member is sterile.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 13:01 MST)

Anthony Dekker, D.O.

430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATES: 6/08/2022, 10/01/2019, 3/25/2016, 7/3/2015, 4/15/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 U.S.C. 1396d (a), Division Medical Policy Manual, 310-P

PURPOSE

This policy establishes requirements for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPDST) services.

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Diagnostic" means determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

3. "Early" means in the case of a child already enrolled with an AHCCCS Contractor, as soon as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

4. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Periodic" means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

6. "Screening" means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more

definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

7. "Treatment" means any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening.

POLICY

A. EPSDT / Well Child Visit

The EPSDT/Well Child visit is all-inclusive and includes the following:

1. A comprehensive health and Developmental history, including growth and Developmental Screening which includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention website: www.cdc.gov/growthcharts/ for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Screening provided by a primary care physician (PCP).

3. Nutritional Assessment provided by a PCP, refer to AdSS Medical Policy 430.

4. Behavioral Health Screening and Services provided by a PCP.

    a. The Division covers behavioral health services for members eligible for EPSDT. PCPs may provide behavioral health services within their scope of practice.

    b. American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment.

5. Developmental Surveillance shall be performed with the PCP at each EPSDT visit.

6. A comprehensive unclothed physical examination.

7. Immunizations

    a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules.

b. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine.

c. Providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

8. Laboratory tests

a. Laboratory including, anemia testing and Diagnostic testing for sickle cell trait.

b. EPSDT covers blood lead Screening for all members at 12 months and 24 months of age and for those members between the ages of 24 through 6 years of age who have not been previously tested or who missed either the 12 month or 24 month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parent/responsible person's concerns. Additional

Screening for children under 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

9. Health education, counseling, and chronic disease self-management.

10. Oral Health Screening

    a. Appropriate oral health Screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant, or nurse practitioner.

    b. Fluoride varnish is limited in a primary care provider's office to 1 every 6 months, during an EPSDT visit for children who have reached 6 months of age with at least 1 tooth erupted, with recurrent applications up to 2 years of age.

11. Appropriate vision, hearing, and speech Screenings

a. EPSDT covers eye examinations as appropriate to age per the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools.

b. Ocular photo screening with interpretation and report, bilateral is covered for children ages three through 6 as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional chart-based vision Screening techniques. Ocular photo screening is limited to a lifetime coverage limit of 1.

c. Automated visual Screening is for vision Screening only, and not recommended for or covered when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

d. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT Screenings, subject to medical necessity. Frames for eyeglasses are also covered.

12. Tuberculosis (TB) Screening

a. Tuberculin skin testing as appropriate to age and risk.

b. Confirmed or suspected as having TB,

c. In jail or prison during the last 5 years,

d. Living in a household with an HIV-infected individual or the child is infected with HIV, and/or

e. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

B. Sick Visit Performed in Addition to an EPSDT

A “sick visit” can be performed at the same time as an EPSDT visit:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation Management service, and.

2. The “sick visit” is documented on a separate note.

3. History, exam, and member/responsible person components of the separate “sick visit” already performed during an EPSDT visit are not to be considered when determining the level of the additional services. An insignificant or trivial

problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.

C. AdSS Specific Requirements

For AdSS specific requirements, see AdSS Medical Policy 430.

D. Requirements for the EPSDT Program Plan Checklist

The Division and AdSS shall have a written EPSDT Program Plan Checklist that addresses minimum requirements. For AdSS specific requirements, see AdSS Medical Policy 430.

1. Provider Requirements

   EPSDT services shall be provided according to community standards of practice and Division rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules. Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of screening services.

a. Providers are required to provide health counseling/education at initial and follow-up visits.

b. Refer to the specific AdSS for managed care members and to the Division for Tribal Health Plan (THP) members, regarding (Prior Authorization) PA requirements.

c. A PCP referral is not required for Naturopathic services.

2. Additionally, providers shall adhere to the below specific standards and requirements for the following covered services, see AdSS Medical Policy 430:

a. Breastfeeding Support

b. Immunizations

c. Blood Lead Screening

d. Organ and Tissue Transplantation Services

Refer to AMPM Policy 310-DD for information regarding AHCCCS-covered transplants.

e. Metabolic Medical Foods

If a Division member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to AMPM Policy 310-GG.

f. Nutritional Therapy

i. The Division covers nutritional therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

ii. PA is required from the AdSS or Tribal ALTCS Case Manager or The Division for Tribal Health Plan (THP) members for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy.

g. Oral Health Services

As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health Screening. A Screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy, see AMPM Policy 431.

h. Cochlear and Osseointegrated Implantation

i. Cochlear implantation

j. Conscious Sedation

The Division covers conscious sedation for members receiving EPSDT services.

k. Behavioral Health Services

The Division covers behavioral health services for members eligible for EPSDT services as described in Contract and Policy. EPSDT behavioral health services include the services necessary to correct or ameliorate

mental illnesses and conditions discovered by the Screening services.

For the diagnosis of behavioral health conditions including, but not limited to Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

l. Religious Non-Medical Health Care Institution Services

The Division covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

m. Care Management Services

The Division covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a

child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

n. Chiropractic Services

The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS to ameliorate the member's medical condition.

o. Personal Care Services

The Division covers personal care services, as appropriate, for members eligible for EPSDT services.

p. Incontinence Briefs

q. Medically Necessary Therapies

The Division covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the Screening services. Therapies are

covered under both an inpatient and outpatient basis when medically necessary.

E. AdSS Oversight and Monitoring

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 16:32 PDT)

Anthony Dekker, D.O.

431 DENTAL/ORAL HEALTH SERVICES FOR EPSDT ELIGIBLE MEMBERS

REVISION DATE: 2/7/2024, 6/8/2022
REVIEW DATE: 7/26/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 U.S.C. 1396d(a), 9 A.A.C. 22, Article 2; A.R.S. §36.-551, A.R.S. § 14-5101; AMPM 431 Attachment B, AMPM Policy 430 Attachment A, AMPM Policy 431 Attachment A

PURPOSE

This policy establishes AdSS requirements for dental/oral health care for Members under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

DEFINITIONS

1. "Dental Home" means the ongoing relationship between the dentist and the Member, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The Dental Home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A Dental Home addresses anticipatory guidance and

preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate. [American Academy of Pediatric Dentistry (AAPD)].

2. "Dental Provider" means an individual licensed as specified in A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
   a. Independently engage in the practice of dentistry as specified in A.R.S. § 32-1202,
   b. A dentist as specified in A.R.S. § 32-1201,
   c. A dental therapist as specified in A.R.S. § 32-1201,
   d. A dental hygienist as specified in A.R.S. § 32-1201, or
   e. An affiliated practice dental hygienist as specified in A.R.S. § 32-1201.
3. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include Screening services, vision

services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. "Informed Consent" means an agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by the Member or Responsible Person with no minimization of known dangers of any procedures.
5. "Medically Necessary" means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care. A PCP may be a physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or a naturopathic physician for AHCCCS Members under the age of 21 receiving EPSDT services. The PCP shall be an individual, not a group or association of individuals, such as a clinic.
8. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.

9. "Referral" means a verbal, written, telephonic, electronic, or in-person request for health services.
10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551.
11. "Screening" means the regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, Screening and diagnosis are not synonymous.
12. "Treatment Plan" means a written plan of services and therapeutic interventions based on a complete assessment of a Member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall require an oral health Screening to be conducted by a PCP as part of an EPSDT Screening.
2. The AdSS shall require oral health Screenings as part of the physical examination are performed by a:
    a. Physician,
    b. Physician's assistant, or
    c. Nurse practitioner.
3. The AdSS shall require PCPs to refer EPSDT Members for appropriate services based on needs identified through the Screening process and for routine oral health care based on the AHCCCS EPSDT Periodicity Schedule.
4. The AdSS shall require the Referral be documented on the EPSDT Clinical Sample Template as specified in AMPM Policy 430, Attachment E and in the Member's medical record.

5. The AdSS shall require one of the following Referrals to a dental Provider to be made depending on the results of the oral health screening:
    a. Urgent Referrals as expeditiously as the Member's health condition requires, but no later than three days of request; or
    b. Routine referrals within 45 calendar days of request.
6. The AdSS shall reimburse PCPs who have completed the AHCCCS-required training for fluoride varnish applications completed at the EPSDT visits for Members as early as six months of age with at least one tooth eruption.
7. The AdSS shall reimburse PCPs according to AHCCCS-approved fee schedules for additional fluoride applications occurring every three months during an EPSDT visit until the Member's fifth birthday.
8. The AdSS shall not permit the application of fluoride varnish by the PCP to take the place of an oral health visit.

9. The AdSS shall require providers to submit a copy of their certificate upon completion of the required training prior to payment being issued for PCP-applied fluoride varnish.

B. DENTAL HOME

1. The AdSS shall require the Dental Home provides:
    a. Comprehensive oral health care including acute care and preventive services in accordance with AMPM 431 Attachment A;
    b. Comprehensive assessment for oral diseases and conditions;
    c. Individualized preventive dental/oral health program based upon a caries-risk assessment and a periodontal disease risk assessment;
    d. Anticipatory guidance about the following growth and development issues;
        i. Teething,
        ii. Digit,
        iii. Pacifier habits, or

iv. Similar issues.

e. A plan for acute dental/oral trauma;

f. Information about proper care of the child's teeth and gingivae, including the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues;

g. Dietary counseling; and

h. Referrals to dental specialists when care cannot directly be provided within the Dental Home.

2. The AdSS shall require Members to be assigned a Dental Home by six months of age or upon enrollment and seen by a dentist for routine preventative care according to the AMPM 431 Attachment A.

3. The AdSS shall require Providers to refer Members with identified additional oral health care concerns for evaluation or treatment.

4. The AdSS shall inform PCPs to refer EPSDT Members for a dental/oral health assessment at an earlier age, if their oral

health screening reveals potential carious lesions or other conditions requiring assessment or treatment by a dental professional.

5. The AdSS shall inform EPSDT Members that they are allowed to self-refer to a dentist who is included in the AdSS provider network.

C. COVERED SERVICES

1. The AdSS shall cover the following dental/oral health services:
   a. Emergency dental/oral services including:
      i. Treatment for pain, infection, swelling or injury;
      ii. Extraction of:
         a) Symptomatic, infected, and non-restorable primary and permanent teeth, and
         b) Retained and symptomatic primary teeth.
      iii. General anesthesia, conscious sedation, or anxiolysis sedation where Members respond normally to verbal commands, when local anesthesia is contraindicated

or when management of the Member requires it, as specified in AMPM430.

b. Preventive dental/oral health services provided as specified in AMPM Policy 431, Attachment A:

i. Diagnostic services including the following comprehensive and periodic examinations;

a) Two oral examinations, and two oral prophylaxis and fluoride treatments per Member per year for Members up to21 years of age;

b) Fluoride varnish four times a year for Members up to five years of age; and

c) Additional examinations or treatments deemed Medically Necessary through the AdSS Prior Authorization process.

ii. Radiology services Screening for diagnosis of dental abnormalities or pathology, including:

a) Panoramic or full-mouth x-rays;

b) Supplemental bitewing x-rays; and

c) Occlusal or periapical films, as Medically Necessary and following the recommendations by the American Academy of Pediatric Dentistry.

iii. Panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit shall be deemed Medically Necessary through the AdSS PA process.

iv. The following preventive services:

a) Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to Member, if able, or to the Responsible Person;

b) Application of topical fluorides and fluoride varnish with the exception of a prophylaxis

paste containing fluoride or fluoride mouth rinses;

c) Dental sealants for first and second molars are covered twice per first or second molar, per Provider or location, allowing for three years intervention between applications up to 15 years of age which includes the ADHS school-based dental sealant program and the participating providers;

d) Additional applications deemed medically necessary and require prior authorization (PA); and

e) Space maintainers when posterior primary teeth are lost and when deemed Medically Necessary through the AdSS PA process.

c. All of the following, although potentially subject to a PA as specified in the AdSS Dental Provider Manuals, when they are considered Medically Necessary and cost effective:

i. Periodontal procedures, scaling, root planning, curettage, gingivectomy, and osseous surgery;

ii. Crowns;

iii. Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless a third molar is functioning in place of a missing molar;

iv. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;

v. Restorations of anterior teeth for children under the age of five, when Medically Necessary;

vi. Extraction for children five years and over, with primary anterior tooth decay,, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the Dental Provider;

vii. Removable dental prosthetics, including complete dentures and removable partial dentures when medically necessary;

viii. Orthodontic services and orthognathic surgery, when these services are Medically Necessary to treat a handicapping malocclusion and determined to be the primary treatment of choice or an essential part of an overall Treatment Plan developed by both the PCP and the dentist in consultation with each other.

ix. Conditions that may require the following orthodontic treatment:

a) Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;

b) Trauma requiring surgical treatment in addition to orthodontic services;

c) Skeletal discrepancy involving maxillary or mandibular structures; or

d) Other severe orthodontic malformations that meet PA criteria.

2. The AdSS shall not cover services or items furnished solely for cosmetic purposes.

D. PROVIDER REQUIREMENTS

1. The AdSS shall require that dental/oral health services are provided by AHCCCS-registered dental Providers.
2. The AdSS shall require a written Informed Consent for examination or any preventative treatment measure, excluding irreversible or invasive procedure , is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.
3. The AdSS shall require a separate written consent is completed for any irreversible or invasive procedure.
4. The AdSS shall require Providers review and sign a written Treatment Plan with the Member or Responsible Person receiving a copy of the complete Treatment Plan.

5. The AdSS shall require all Providers complete the appropriate Informed Consents and Treatment Plans for Division Members, in order to provide quality and consistent care in a manner that protects and is easily understood by the Member or Responsible Person.
6. The AdSS shall require consents and Treatment Plans to be in writing, signed and dated by both the Provider and the Member or Responsible Person, if:
   a. The Member is under 18 years of age, or
   b. The Member is 18 years of age or older and considered an incapacitated person as defined in A.R.S. § 14-5101.
7. The AdSS shall require Providers maintain completed consents and Treatment Plans in the Member's chart which are subject to audit.

E. AdSS REQUIREMENTS

1. The AdSS shall:

a. Conduct annual outreach efforts to Members receiving oral health care through school-based or mobile unit Providers in or out of network, to:
   i. Ensure Members are aware of their Dental Home Provider and contact information; and
   ii. Let Members know when school-based or mobile unit Providers are not accessible, they can receive ongoing-access to care through the Dental Home Provider.

b. Conduct the following written Member educational outreach topics at least once every 12 months, addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period, as specified in AMPM Chapter 400, Exhibit 400-3:
   i. Dental Home,
   ii. Importance of oral health care,
   iii. Dental decay prevention measures,
   iv. Recommended dental periodicity schedule, and

v. Other AdSS-selected topics.

c. Educate Providers in the importance of offering continuously accessible, coordinated, family-centered care.

d. Develop processes to:

i. Ensure Members are enrolled into a Dental Home by six months of age, to allow for an ongoing relationship providing comprehensive oral health care;

ii. Allow Members the choice of Dental Providers from within the AdSS' Provider network and provide Members with instructions on how to select or change a Dental Home Provider;

iii. Automatically assign a Provider if the Member does not select a Dental Home Provider.

iv. Connect all Members to a Dental Home before one year of age or upon assignment to the AdSS;

v. Inform Members of selected or assigned Dental Home Provider contact information and recommended dental visit schedule;

vi. Monitor Member participation with the Dental Home and provide outreach to Members who have not completed visits as specified in AMPM 431 Attachment A;

vii. Notify all Members or Responsible Person of visit as specified in AMPM 431 Policy Attachment A and AMPM 430 Attachment A.

viii. Notify the Member or Responsible Person regarding due dates of biannual dental visits and sending a second notice if a dental visit has not taken place. a second notice shall be sent.

ix. Monitor Provider engagement related to scheduling and follow-up of missed appointments to ensure care consistent with AMPM Policy 431 Attachment A for assigned EPSDT Members.

e. Develop and implement processes to reduce no-show appointment rates for dental/oral health services;

f. Provide targeted outreach to those Members who did not show for appointments;

g. Encourage all dental/oral health Providers to schedule the next dental/oral health Screening at the current office visit, particularly for children 24 months of age and younger;

h. Advise Members about:

   i. How to obtain medically necessary transportation, as specified in AMPM Policy 310-BB, including

   ii. Scheduling appointments to obtain EPSDT services, and

i. No copayment or other charge for EPSDT Screening and resultant services.

j. Require the use of AMPM Policy 431 Attachment A by all contracted dental/oral health Providers.

k. Adhere to the Dental Uniform Prior Authorization List (List) as specified on the AHCCCS website under Resources: Guides-Manuals-Policies and:

i. Submit all requests for changes to the List to the AHCCCS Division of Health Care Services (DHCS) designated Operations and Compliance Officer for review; and

iii. Include supporting documentation and rationale for requests to propose changes to the List.

l. Adhere to the Dental Uniform Warranty List as specified on the AHCCCS website under Resources-Guides-Manuals-Policies and:

i. Submit all requests for changes to the list to the AHCCCS DHCS designated Operations and Compliance Officer for review; and

ii. Include supporting documentation and rationale for request to propose changes to the List.

iii. The AdSS shall provide Oral Health Care Member Outreach as outlined in AMPM Exhibit 400-3.

F. REQUIREMENTS FOR THE DENTAL ANNUAL PLAN

1. The AdSS shall have a written Dental Annual Plan that:
   a. Addresses minimum requirements as specified in this policy;
   b. Addresses the objectives of the AdSS' program that are focused on achieving Division and AHCCCS requirements; and
   c. Incorporate monitoring and evaluation activities for these minimum requirements as outlined in AMPM 431 Attachment B.
2. The AdSS shall submit the Dental Annual Plan no later than July 31st to the Division's Dental Director through the Compliance Unit for review and approval.
3. The AdSS shall require the following is contained in the written Dental Annual Plan:
   a. Narrative Plan that includes:

i. A written narrative description of all planned dental activities to address the AdSS minimum requirements for dental/oral health services, as specified in this policy;

ii. A narrative description of the AdSS activities to identify Member needs and coordination of care; and

b. Follow-up activities to ensure appropriate treatment is received in a timely manner.

c. Dental Work Plan Evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives;

d. Dental Work Plan that includes:

i. Specific measurable objectives based on AHCCCS established Performance Measure Performance Standards (PMPS) as adopted by the Division;

iii. Strategies and specific measurable interventions to accomplish the following objectives:

a) Member outreach,

b) Provider education, and

c) Provider compliance with mandatory components of the Dental Program.

d. Targeted implementation and completion dates of work plan activities;

e. Assigned local staff positions responsible and accountable for meeting each established goal and objective;

f. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation; and

g. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.

F. AFFILIATED PRACTICE DENTAL HYGIENIST

1. The AdSS shall require the following in addition to the requirements as specified in A.R.S. §§ 32-1281 and 32-1289:

a. Both the dental hygienist and the dentist in the affiliated practice relationship are registered AHCCCS Providers;

b. The affiliated practice dental hygienist maintains individual patient records of the following for Division Members in accordance with the Arizona State Dental Practice Act:

   i. Member identification,

   ii. Responsible Person identification,

   iii. Signed authorization for services,

   iv. Patient medical history, and

   v. Documentation of services rendered.

c. The affiliated practice dental hygienist registers with AHCCCS and is identified as the treating Provider under his or her individual AHCCCS Provider identification number or National Provider Identification (NPI) number. ,

d. The affiliated practice dental hygienist and the dentist with whom he or she is affiliated is a credentialed network Provider if the services are to be billed to an AdSS;

e. The affiliated practice dental hygienist is identified as the treating Provider under their individual AHCCCS Provider identification number or NPI number when practicing under an affiliated practice agreement;

f. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with:

   i. State statute and regulations;

   ii. AHCCCS policy;

   iii. Provider agreement; and

   iv. Affiliated practice agreement.

g. Affiliated practice dental hygienists provide documentation of the affiliation practice agreement with an AHCCCS registered dentist that is recognized by the dental board confirming the affiliation agreement.

h. Reimbursement for dental radiographs is restricted to Providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

Supplemental Information

A Screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. The oral health screening does not substitute for examination through direct Referral to a dental Provider.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website, https://www.aap.org/en/patient-care/oral-health/oral-health-education-and-training/
Refer to the website for training that covers caries-risk assessment, fluoride varnish, and counseling.

Crowns:
Stainless-steel crowns are used for both primary and permanent posterior teeth when appropriate.
Composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth.

Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for Members who are 18 to 21 years of age.

Certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

In cases where the Performance Measure Performance Standards have been met, other generally accepted benchmarks that continue the AdSS improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards).

Dental work plan includes specific measurable goals and objectives aimed at enhancing the Dental Program when the PMPS have been met.

Signature of Chief Medical Officer: Anthony Dekker (Feb 1, 2024 13:51 MST)
Anthony Dekker, D.O.

450 OUT-OF-STATE PLACEMENTS FOR CHILDREN OR YOUNG ADULTS FOR BEHAVIORAL HEALTH TREATMENT

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Behavioral Health Covered Services Guide, AMPM Exhibit 450-1
DELIVERABLES: Out of State Placements

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

The purpose of this Policy is to provide criteria and procedures for the Division's AdSS in the event that an out-of-state placement is clinically necessary and supported by the Child and Family Team (CFT) or Adult Recovery Team (ART).

It may be necessary to consider an out-of-state placement for a child or young adult eligible for the Division to meet the member's unique circumstances or clinical needs. The following factors may lead a member's CFT or ART to consider the temporary out-of-state placement:

A. The member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition.

B. An out-of-state placement's approach to treatment incorporates and supports the unique cultural heritage of the member.

C. A lack of current in-state bed capacity, and/or

D. Geographical proximity encourages support and facilitates family involvement in the member's treatment.

General Requirements

Decisions to place members in out-of-state placements for behavioral health care and treatment must be examined and made after the CFT or ART have reviewed all other in-state options. Other options may include single case agreements with in-state providers or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions.

Services provided out-of-state must meet the same requirements as those rendered in-state. AdSS must also ensure that out-of-state providers follow all Division reporting requirements, policies, and procedures, including appointment standards and timelines specified in AdSS Operations Manual, Policy 417.

Out of state placement providers must coordinate with the AdSS to provide required updates.

The following circumstances must exist in order to consider an out-of-state placement for a member:

A. The CFT or ART explore all applicable and available in-state services and placement options and,

   1. Determine that the services do not adequately meet the specific needs of the member, or

   2. In-state facilities decline to accept the member.

B. The member's family/guardian agrees with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship).

C. The out-of-state placement is registered as an AHCCCS provider.

D. Prior to placement, the AdSS ensures the member has access to non-emergent medical needs by an AHCCCS registered provider,

E. The out-of-state placement meets the Arizona Department of Education Academic Standards, and

F. A plan for the provision of non-emergency medical care is established.

Conditions Before a Referral for Out-of-State Placement is Made

The AdSS must ensure that documentation in the clinical record indicates the following conditions have been met before a referral for an out-of-state placement is made:

A. All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT or ART and found not to meet the member's needs.

B. A minimum of three in-state facilities have declined to accept the member.

C. The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement.

D. The CFT or ART has documented how they will remain active and involved in service planning once the out-of-state placement has occurred.

E. An ISP has been developed.

F. All applicable prior authorization requirements have been met, including a second-level review completed by the Division's Chief Medical Officer/designee.

G. The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member.

H. Coordination has occurred with all other state agencies involved with the member, including notification to the Medical Director of the Division of Developmental Disabilities (DDD).

I. Coordination has occurred between the member's primary care provider and the AdSS to develop a plan for the provision of any necessary, non-emergency medical care. The AdSS must identify who is responsible for this coordination. All providers are registered AHCCCS providers.

Individual Service Plan (ISP)

For a member placed out-of-state, the ISP developed by the CFT or ART (including the member's Support Coordinator) must require that:

A. Discharge planning is initiated at the time of admission and includes:

1. The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services

2. The possible or proposed in-state residence where the member will be returning

3. The recommended services and supports required once the member returns from the out-of-state placement

4. How effective strategies implemented in the out-of-state placement will be transferred to the members' subsequent in-state placement

5. The actions necessary to integrate the member into family and community life upon discharge, and

6. Review by the CFT or ART of the member's progress with the clinical staff at least every 30 days.

B. When appropriate, the member's family/guardian is involved throughout the duration of the placement. Involvement may include family counseling in person or by teleconference or video-conference.

Home passes are allowed as clinically appropriate and in accordance with the AHCCCS Behavioral Health Covered Services Guide. For youth in Department of Child Safety (DCS) custody, approval of home passes are determined in collaboration with DCS.

C. The member's needs, strengths, and cultural considerations have been addressed.

Initial Notification to Division Health Care Services

A. The AdSS must notify the Division by emailing a completed AHCCCS Out-of-State Placement Form (AMPM Exhibit 450-1, adopted by the DIvison for use by the AdSS) to Division Health Care Services under the following circumstances:

1. Upon notification or discovery that a member is in an out-of-state behavioral health residential treatment facility

2. Prior to a referral for an out of state placement (approval from the Division of

all planned out of state placements must be obtained prior to making a referral for out-of-state placement, in accordance with the criteria outlined in this Policy)

3. Prior to placement in an out-of-state placement.

B. Prior authorization is required for all out-of-state placements.

C. The Division Health Care Services will review the information on the AHCCCS Out-of-State Placement Form (Exhibit 450-1) and render an approval within 1-3 business days. If the information is incorrect or incomplete, the form will be returned for correction. The corrected form must be resubmitted for approval.

Required Updates to Division Health Care Services

A. The AdSS must submit updates to the Division Health Care Services regarding the member's progress in meeting the identified criteria for discharge.

B. The progress update, using the AHCCCS Out-of-State Placement Form (Exhibit 450-1), must be emailed to Division Health Care Services every 30 days that the member remains in the out-of-state placement. The 30-day update timeline is based upon the date of Division approval of the out-of-state placement. If a 30-day update date falls on a weekend or holiday, it must be submitted on the next business day.

Required Reporting of an Out-of-State Provider

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, injuries from seclusion/restraint implementations as described in Division Medical Manual Policy 960.

510 PRIMARY CARE PROVIDERS

REVISION DATE: 4/17/2024, 9/6/2023
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; A.R.S. Title 32, Chapter 13 or Chapter 17; A.R.S. Title 32, Chapter 25; A.R.S. Title 32, Chapter 15, 42 CFR 457.1230(c), 42 CFR 438.208(b)(1).

PURPOSE

This policy establishes requirements regarding Primary Care Providers participating in Arizona Health Care Cost Containment System (AHCCCS) programs. This policy applies to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. §1-301.
2. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21. EPSDT services include:

a. Screening services,

b. Vision services,

c. Dental services,

d. Hearing services, and

e. All other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Non-Contracting Provider" means an individual or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.

5. "Primary Care Provider" or "PCP" means a person who is responsible for the management of the member's health care. A PCP may be a:
   a. Person licensed as an allopathic or osteopathic physician,
   b. Practitioner defined as a licensed physician assistant, or
   c. Certified nurse practitioner.
6. "Provider" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
7. "Resident Physician" means doctors who have graduated from medical school and are completing their residency in a specialty.
8. "Teaching Physician" means a physician other than another Resident Physician who involves residents in the care of his or her patients.

POLICY

A. PRIMARY CARE PROVIDER AND RESPONSIBILITIES

The AdSS shall ensure PCPs are:

a. Providing initial and primary care services to assigned Members;

b. Initiating, supervising, and coordinating referrals for specialty care and inpatient services;

c. Maintaining continuity of Member care; and

d. Maintaining the Member's medical record as specified in AHCCCS Medical Policy Manual (AMPM) 940.

B. PROVISION OF INITIAL AND PRIMARY CARE SERVICES

1. The AdSS shall ensure PCPs are rendering and providing the following covered preventive and primary care services to Members:

   a. Health screenings,

   b. Routine illness,

   c. Maternity services if applicable,

   d. Immunizations, and

   e. EPSDT services.

2. The AdSS shall ensure all Members under the age of 21 receive health screening and services, to correct or ameliorate defects or

physical and behavioral illnesses or conditions identified in an EPSDT screening, as specified in AMPM Policy 430.

3. The AdSS shall ensure Members 21 years of age and over receive health screening and medically necessary treatment as specified in AMPM Chapter 300.

C. BEHAVIORAL HEALTH SERVICES PROVIDED BY THE PRIMARY CARE PROVIDER

1. The AdSS shall cover medically necessary, cost-effective, Federal and State reimbursable behavioral health services provided by a PCP within their scope of practice including monitoring and adjustments of behavioral medications.
2. The AdSS shall ensure prior authorization is obtained for antipsychotic class of medications, if required, to include monitoring and adjusting behavioral health medication as specified in AMPM 310-V.
3. The AdSS shall ensure PCPs coordinate and collaborate with behavioral health providers.

D. PRIMARY CARE COORDINATION RESPONSIBILITIES

1. The AdSS shall ensure PCPs in their care coordination role serve as a referral agent for specialty and referral treatment and services for physical or behavioral health services as needed for Members to ensure coordinated quality care that is efficient and cost effective.
2. The AdSS shall ensure the following PCP's coordination responsibilities are met:
    a. Referring Members to Providers or hospitals within the AdSS's network;
    b. Referring Members to Non-Contracting specialty Providers and non-contracting community benefit organizations if necessary;
    c. Coordinating with the AdSS, or the appropriate entity for Fee-for-service (FFS) members. Appropriate entities for coordination of services for FFS Members include:
        i. Division of Fee-For-Service Management (DFSM) for Members enrolled with a Tribal Regional Behavioral Health Authority (TRBHA),

ii. Tribal Arizona Long Term Care System (ALTCS) for physical and behavioral health services for enrolled FFS members,

iii. American Indian Medical Home (AIMH) for coordination of physical and behavioral health services for American Indian Health Program (AIHP) Members enrolled with an AIMH, to include coordination with TRBHAs when applicable; and

iv. TRBHA for behavioral health services for enrolled FFS Members.

d. Coordinating with a Member's:

i. AdSS care manager,

ii. Provider case manager,

iii. Division Support Coordinator,

iv. Behavioral Health Complex Team,

v. Behavioral Health Provider, and

vi. Division Nurses.

e. Conducting or coordinating follow-up for referral services that are rendered to their assigned Members by:
   i. Other Providers,
   ii. Specialty Providers, or
   iii. Hospitals.

f. Coordinating the following medical care of Members:
   i. Oversight of medication regimens to prevent negative interactive effects;
   ii. Follow-up for all emergency services;
   iii. Coordination of discharge planning post inpatient admission;
   iv. Home visits if medically necessary;
   v. Member education;
   vi. Preventative health services;
   vii. Screening and referral for health-related social needs;
   viii. Coordination of the following services :
      a) Specialty Providers,

b) Laboratory and Diagnostic Testing,

c) Behavioral health services,

d) Therapies including:

1) Occupational,

2) Physical, and

3) Speech language pathology.

e) Durable Medical Equipment,

f) Home health,

g) Palliative care, and

h) Hospice care.

ix. Oversight that care rendered by specialty Providers is appropriate and consistent with each Member's health care needs; and

x. Maintaining records of services provided by physical and behavioral health specialty Providers or hospitals.

g. Coordinating care for behavioral health medication management to include:

i. Requiring and ensuring coordination of referral to the behavioral health Provider when a PCP has initiated medication management services for a Member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the Member should be referred to a behavioral health Provider for evaluation or continued medication management.

ii. Policies and procedures that address the following:

a) Guidelines for PCP initiation and coordination of a referral to a behavioral health Provider for medication management;

b) Guidelines for transfer of a member with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation for ongoing treatment coordination, as applicable;

c) Protocols for notifying entities of the member's transfer, including:

1) Reason for transfer,

2) Diagnostic information, and

3) Medication history.

d) Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information;

e) Protocols for transition of prescription services, including:

1) Notification to the appropriate Providers of the Member's current medications and timeframes for dispensing and refilling medications during the transition period,

2) Ensuring that the Member does not run out of prescribed medication prior to the first appointment with the behavioral health Provider, allowing for at least a

minimum of 90 days transition between Providers,

3) Forwarding all medical information, including the reason for transfer to the behavioral health Provider prior to the Member's first scheduled appointment.

f) AdSS monitoring activities to ensure that Members are appropriately transitioned for care and receive the services they are referred for.

E. PRIMARY CARE PROVIDER ASSIGNMENT AND APPOINTMENT STANDARDS

1. The AdSS shall ensure newly enrolled Members are assigned to a PCP and notified after the assignment within 12 Business Days of the enrollment notification.
2. The AdSS shall ensure that AHCCCS-registered PCPs receive an AHCCCS Provider ID number.

3. The AdSS shall maintain a current file of Member PCP assignments and accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data.
4. The AdSS shall make PCP assignment rosters and clinical information regarding Member's health and medications, including behavioral health providers, available to the assigned PCP within 10 Business Days of a Provider's request as specified in ACOM Policy 416.
5. The AdSS shall allow Members to choose PCPs available within their network.
6. The AdSS shall automatically assign a PCP if a Member does not select a PCP.
7. The AdSS shall ensure the network of PCPs is sufficient to provide Members with available and accessible service within the time frames specified in ACOM Policy 417.
8. The AdSS shall provide information to the Member on how to contact the Member's assigned PCP.

9. The AdSS shall develop procedures to ensure enrolled pregnant Members are assigned to and are receiving appropriate care from: a qualified physician, a PCP who provides obstetrical care, or referred to an obstetrician as specified in AMPM Policy 410.
10. The AdSS shall assign Members with complex medical conditions who are age 12 and younger to board certified pediatricians.
11. The AdSS shall develop a methodology to assign Members to Providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

F. REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALITY CARE

The AdSS shall ensure referral procedures are in place for PCPs for the appropriate availability and monitoring of health care services that include the following:

a. Utilization of the AdSS specific referral process.
b. Definition of who is responsible for initiating referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral.

c. Specifications addressing the timely availability of appointments as specified in ACOM Policy 417.

d. Specifications and procedures for linking specialty and other referrals to the claims management system, such as through the Prior Authorization process.

G. PHYSICIAN ASSISTANT (PA) AND NURSE PRACTITIONER (NP) VISITS IN A NURSING FACILITY

The AdSS shall cover initial and any subsequent visits to a Member in a nursing facility made by PA or NP, when all of the following criteria are met:

a. The PA or NP is not an employee of the facility, and

b. The source of payment for the nursing facility stay is Medicaid.

H. MEDICAL RESIDENT VISITS UNDER SPECIFIC CIRCUMSTANCES

1. The AdSS shall ensure Resident Physicians providing service without the presence of a Teaching Physician have completed six months of post graduate work in an approved residency program.

2. The AdSS shall allow medical residents to provide low-level evaluation and management services to Members in designated settings without the presence of the Teaching Physician as specified in AMPM 510 Section H.

SUPPLEMENTAL INFORMATION

Refer to AMPM Chapter 600 for information regarding specific AHCCCS requirements for participating providers.

Refer to ACOM Policy 325 for additional information related to Contractor responsibilities and PCP assignments pertaining to providers participating in Targeted Investments 2.0

Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

FFS members have freedom of choice and are not required to have an assigned PCP. FFS members may receive services from any AHCCCS registered PCP and any IHS/638 facility.

Signature of Chief Medical Officer: Anthony Dekker (Apr 10, 2024 10:42 PDT)
Anthony Dekker, D.O.

520 MEMBER TRANSITIONS

REVISION DATE: 5/10/2023, 1/27/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.300; 42 CFR 438.62; 42 CFR 440.70; 42 CFR 457.1216; 42 CFR 431.300 et seq; A.R.S. §§ 36-2931; A.R.S. §§ 36-2901.01; A.R.S. §§ 36-2981; AMPM 520; AMPM 1620-H; AMPM 1620-M; AMPM Exhibit 1620-9; AdSS 310-P

PURPOSE

This policy establishes requirements for Division of Developmental Disabilities (Division) Member Transitions between the Administrative Services Subcontractors (AdSS), Fee-for-Service (FFS) programs, and other AHCCCS contractors. It applies to the Administrative Services Subcontractors.

DEFINITIONS

1. “Enrollment Transition Information” or "ETI” means Member specific information the relinquishing contractor shall complete and transmit to the receiving contractor or Fee-For-Service program for those Members requiring coordination of services as a result of transitioning to another contractor or FFS program.
2. “Member” means an individual who is receiving services from the

Division of Developmental Disabilities (Division).

3. "Member Transition" means the process during which Members change from one contractor or Fee-for-Service (FFS) program to another.

4. "Medical Equipment and Appliances" means an item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and

   a. Is customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness, disability, or injury,

   b. Can withstand repeated use, and

   c. Can be reusable by others or is removable

5. "Special Health Care Needs" or "SHCN" means a serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by Members generally that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP). All Division Members are designated as individuals with

Special Health Care Needs.

POLICY

A. MEMBER TRANSITIONS

1. The AdSS shall identify and facilitate coordination of care for all Members eligible for Arizona Long Term Care System (ALTCS) during:
   a. Changes or transitions between health plans,
   b. Changes in service areas, or
   c. Changes in health care providers as specified in AMPM 520.
2. The AdSS shall work collaboratively with Members with special circumstances which may require additional or distinctive assistance during a period of transition to ensure Members do not experience a gap in services.
3. The AdSS shall develop policies or protocols to address the transition of Members with the following medical conditions or special circumstances:
   a. Pregnancy;

b. Major organ or tissue transplantation services which are in process;

c. Chronic illness, which has placed the Member in a high-risk category or resulted in hospitalization or placement in nursing, or other facilities;

d. Significant medical or behavioral health conditions that require ongoing specialist care and appointments;

e. Chemotherapy or radiation therapy;

f. Dialysis;

g. Hospitalization at the time of transition;

h. Members with the following ongoing health needs:

i. Durable Medical Equipment, including ventilators and other respiratory assistance equipment;

ii. Home health services;

iii. Medically necessary transportation on a scheduled basis;

iv. Prescription medications; or

v. Plan management services.

i. Members who frequently contact AHCCCS, State and local officials, the Governor's Office or the media;

j. Members with qualifying Children's Rehabilitation Services (CRS) conditions or are transitioning into adulthood;

k. Members diagnosed with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS);

l. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant;

m. Members enrolled in the ALTCS program who are elderly or have a physical or developmental disability;

n. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP);

o. Members who are diagnosed with a Serious Mental Illness (SMI).

p. Any child that has an Early Childhood Service Intensity Instrument Child and Adolescent Level of Care Utilization System (ECSII/CALOCUS) score of 4+;

q. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system;

r. Substance exposed newborns and infants diagnosed with Neonatal Abstinence Syndrome (NAS);

s. Members diagnosed with Severe Combined Immunodeficiency (SCID);

t. Members with a diagnosis of autism or who are at risk for autism;

u. Members diagnosed with opioid use disorder, separately tracking pregnant Members and Members with co-occurring pain and opioid use disorder;

v. Members enrolled with the Division of Child Safety Comprehensive Health Program (CHP);

w. Members who transition out of the CHP up to one-year post transition;

x. Members identified as a High Need or High Cost Member;

y. Members on conditional release from Arizona State Hospital;

z. Other services not indicated in the State Plan for eligible Members but covered by Title XIX and Title XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible Members, including Members whose conditions require ongoing monitoring or screening;

4. The AdSS shall ensure members have received prior authorization or approval for the following at the time of transition:

a. Scheduled elective surgery(ies);

b. Procedures or therapies to be provided on dates after their transition, including post-surgical follow-up visits;

c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30 calendar day period;

d. Behavioral health services;

e. Appointments with a specialist located out of the AdSS service area; and

f. Nursing facility admission.

B. NOTIFICATION REQUIREMENTS

1. The relinquishing AdSS shall provide relevant information regarding Members who transition to a receiving AdSS.
2. The relinquishing AdSS shall utilize the ALTCS Enrollment Transition Information (ETI) for those Members with special circumstances who are transitioning enrollment to another AdSS.
3. The relinquishing AdSS shall complete and electronically transmit the appropriate ETI Form to the receiving AdSS or FFS program no later than 10 business days from the date of receipt of AHCCCS notification.
4. The relinquishing AdSS shall be responsible for covering the Member's care for up to 30 calendar days if they fail to notify the receiving AdSS of transitioning Members with special circumstances, or fail to send the completed ALTCS Enrollment Transition Information.
5. The AdSS shall have protocols for the transfer of pertinent medical records and the timely notification of Members,

subcontractors, or other providers, as appropriate during times of transition.

6. The receiving AdSS shall provide new Members with its Member Handbook, provider directory, and emergency numbers as specified in ACOM Policy 460.
7. The receiving AdSS shall follow up with the Member to address the needs of the Member identified on the ETI form.
8. The receiving AdSS shall extend previously approved prior authorizations for a minimum period of 30 calendar days from the date of the Member's transition, unless a different time period is mutually agreed to by the Member or Member's representative.
9. The receiving AdSS shall provide at a minimum a 90 calendar day transition period, for children and adults with Special Health Care Needs who have an established relationship with a PCP that does not participate in the receiving AdSS provider network.

C. TRANSITION TO ALTCS

1. The relinquishing AdSS shall coordinate transition with the receiving AdSS or Tribal ALTCS if a Member is approved for ALTCS enrollment.
2. The AdSS shall ensure applicable protocols are followed for any special circumstances of the Member and that continuity and quality of care is maintained during and after the transition.

D. TRANSITION FROM CHILD TO ADULT SERVICES

1. The AdSS shall ensure transitions involving co-occurring behavioral and physical health conditions include the following:
    a. Coordination plan between child providers and the anticipated adult providers;
    b. Process that begins no later than when the child reaches the age of 16;
    c. A transition plan for the Member focused on assisting the Member with gaining the necessary skills and knowledge to become a self-sufficient adult within their capabilities and facilitates a seamless transition from child services to adult services;

d. An SMI eligibility determination that is completed when the adolescent reaches the age of 17, but no later than age 17 and six months; and

e. A coordination plan to meet the unique needs for Members with special circumstances.

2. The AdSS shall ensure any additional stakeholder, behavioral or physical healthcare entity involved with the child shall be included in the transition process, as applicable.

E. MEMBERS HOSPITALIZED DURING ENROLLMENT CHANGE

1. The AdSS shall provide a smooth transition of care for Members who are hospitalized on the day of an enrollment change with the following steps:

a. Notification to the receiving AdSS or FFS Program prior to the date of the transition.

b. Notification to the hospital and attending physician of the transition by the relinquishing AdSS as follows:

i. Notify the hospital and attending physician of the pending transition prior to the date of the transition,

ii. Instruct the providers to contact the receiving AdSS or FFS Program for authorization of continued services,

iii. Cover services rendered to the hospitalized Member for up to 30 days if they fail to provide notification to the receiving AdSS, hospital, and the attending physician, relative to the transitioning Member.

c. Coverage of the hospital stay by the AdSS in which the Member is enrolled upon discharge per Diagnosis Related Group (DRG).

d. Coordination with providers regarding activities relevant to concurrent review and discharge planning.

F. TRANSITION DURING MAJOR TRANSPLANTATION SERVICES

1. The relinquishing and receiving AdSS shall coordinate care and coverage for Members who have been approved for major organ or tissue transplant if there is a change in AdSS or FFS enrollment.

2. Each AdSS shall cover the respective dates of service if a Member changes to a different AdSS while undergoing transplantation at a transplant center that is not an AHCCCS contracted provider.

G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT

1. The AdSS shall have protocols for ongoing care of Members with active or chronic health care needs during the transition period.
2. The receiving AdSS shall have protocols to address the timely transition of the Member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.
3. The AdSS shall ensure pregnant women who transition to a new AdSS within the last trimester of their expected date of delivery be allowed the option of continuing to receive services from their established physician and anticipated delivery site through the postpartum visits included in the all-inclusive maternity care as specific in AMPM 410.

H. MEDICALLY NECESSARY TRANSPORTATION

1. The AdSS shall provide information to new Members on what and how medically necessary transportation can be obtained.
2. The AdSS shall provide information to providers on how to order medically necessary transportation for Members.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

1. The relinquishing AdSS shall:
    a. Cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment; and
    b. Not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100 unit doses.
2. The receiving AdSS shall extend previously approved prior authorizations for a period of 30 calendar days from the date of the Member's transition unless a different time period is mutually agreed to by the Member or Member's representative.
    3. The AdSS shall ensure Member's transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for behavioral health medication management continue on the

medication(s) prescribed by the BHMP until the Member can transition to their PCP.

4. The AdSS shall coordinate care and ensure the Member has a sufficient supply of behavioral health medications to last through the date of the Member's first appointment with their PCP.

J. DISPOSITION OF MEDICAL EQUIPMENT, APPLIANCES, AND MEDICAL SUPPLIES DURING TRANSITION

1. The AdSS shall ensure the disposition of Medical Equipment, appliances, and supplies during a Member's transition period and develop policies that include the following:
   a. Non-customized Medical Equipment
      i. Relinquishing AdSS shall provide accurate information about Members with ongoing Medical Equipment needs to the receiving AdSS or FFS programs.
   b. Customized Medical Equipment

i. Customized Medical Equipment purchased for Members by the relinquishing AdSS will remain with the Member after the transition. The purchase cost of the equipment is the responsibility of the relinquishing AdSS.

ii. Customized Medical Equipment ordered by the relinquishing AdSS but delivered after the transition to the receiving AdSS shall be the financial responsibility of the relinquishing AdSS.

iii. Maintenance contracts for customized Medical Equipment purchased for Members by a relinquishing AdSS will transfer with the Member to the receiving AdSS.

iv. Contract payments due after the transition will be the responsibility of the receiving AdSS, if the receiving AdSS elects to continue the maintenance contract.

c. Augmentative Communication Devices (ACD)

i. A 90-day trial period to determine if the ACD will be effective for the Member, or if it should be replaced with another device.

ii. If a Member Transitions from an AdSS during the 90-day trial period, one of the following shall occur:

1) The device shall remain with the Member if the ACD is proven to be effective. Payment for the device shall be covered by the relinquishing AdSS.

2) The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving AdSS if they elect to continue the maintenance contract.

3) The device shall be returned to the vendor if the ACD is proven to be ineffective. The receiving AdSS shall then coordinate a new device trial and purchase if it is determined to meet the Member's needs.

K. MEDICAL RECORDS TRANSFER

1. The AdSS shall transition medical records timely but no later than within 10 business days from receipt of the request for transfer to ensure continuity of Member care during the time of enrollment change as specified in AMPM 940.

L. OUT OF SERVICE AREA PLACEMENT REFERRALS

1. The AdSS shall initiate a referral for placement of a Member with SMI to a service provider for the purposes of obtaining behavioral health services when:
   a. The resulting relocation of the Member may result in the eligibility source making corresponding changes to a Member's address in the Pre-paid Medicaid Management Information System (PMMIS), or
   b. A change of address to another Geographic Service Area (GSA) will cause the Member with SMI to become enrolled with a RBHA Contractor in the other GSA for both behavioral health and physical health services.

2. The AdSS shall provide services out of state when medically necessary services are not available in state.

Signature of Chief Medical Officer: Anthony Dekker (May 3, 2023 15:22 PDT)
Anthony Dekker, D.O.

530 MEMBER TRANSFERS BETWEEN FACILITIES

EFFECTIVE DATE: April 17, 2024
REFERENCES: AMPM 530

PURPOSE

This policy establishes requirements for the Administrative Services Subcontractors (AdSS) regarding Division of Developmental Disabilities (Division) Member transfers between facilities.

DEFINITIONS

1. "Emergency" means a serious and unexpected situation requiring immediate action to avoid harm to health, life, property, or environment.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Primary Hospital" means hospitals that are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions

by an organized physician staff and have continuous nursing services under the supervision of registered nurses.

4. "Secondary Hospital" means hospitals capable of providing the majority of hospital based services, both general medical and surgical, often Obstetrician (OB) and other services, but limited with regards to specialist access.
5. "Tertiary Hospital" means hospitals with access to a broad range of specialists and equipment necessary and usually receiving their patients from a large catchment area and referral base.

POLICY

A. TRANSFER BETWEEN FACILITIES

1. The AdSS shall ensure coordination activity and data sharing is required when a Member transitions between facilities and levels of care. The methodology for data sharing is determined based on the capability of each entity.
2. The AdSS shall ensure the following criteria are met when a transfer is initiated by the AdSS between inpatient hospital facilities following Emergency hospitalization:

a. The attending Emergency physician, or the attending provider treating the Member, determines that the Member is stabilized for transfer and will remain stable for the period of time required for the distance to be traveled. Such determination is binding on the AdSS responsible for coverage and payment;

b. The receiving physician agrees to the Member transfer;

c. Transportation orders are prepared specifying:

i. The type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

d. A transfer summary accompanies the Member.

3. The AdSS shall comply with Medicaid Managed Care guidelines regarding the coordination of post stabilization care as specified in 42 CFR 438.114 and 42 CFR 422.113.

4. The AdSS shall ensure the following criteria are met when a Member transfers to a lower level care facility:

a. The Member's condition does not require the full capabilities of the transferring facility; or

b. The Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility; and

c. The receiving physician agrees to the Member transfer;

d. Transportation orders are prepared specifying the:

i. Type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

e. A transfer summary accompanies the Member.

5. The AdSS shall ensure the following criteria are met when a Member transfers to a higher level of care facility:

a. The transferring hospital cannot provide the level of care needed to manage the Member beyond stabilization required to transport, or cannot provide the required diagnostic evaluation and consultation services needed;

b. The receiving physician agrees to the Member transfer;

c. Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support; and

d. A transfer summary accompanies the Member.

6. The AdSS shall ensure when the transfer is initiated by the AdSS, the attending Emergency physician, or the attending provider treating the Member and the AdSS Medical Director or designee are responsible for determining whether a particular case meets criteria established in this policy.

SUPPLEMENTAL INFORMATION

Transfer to a lower level of care facility (e.g., Tertiary to Secondary or Primary, or Secondary to Primary Hospital, or transfer to a skilled nursing facility).

Transfers to a higher level of care facility (e.g., Primary to Secondary or Tertiary, or Secondary to Tertiary Hospital).

Signature of Chief Medical Officer: Anthony Dekker (Apr 10, 2024 08:05 PDT)
Anthony Dekker, D.O.

540 OTHER CARE COORDINATION ISSUES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915(k).

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Problem Resolution

The AdSS must establish policies that address problem resolution.

Members Presenting for Care Outside the AdSS's Provider Network

The AdSS must establish procedures for assisting members when they present to a non-contracted provider that include, but are not limited to:

A. Identification of a specific AdSS contact person for assistance

B. Identification of a telephone number to obtain AdSS information

C. Electronic and hard copy (if requested) provider directories.

Members with Special Health Care Needs

A. Members with special health care needs includes all members eligible for the Division.

B. The AdSS must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions requiring treatment or regular care monitoring. The assessment mechanism must identify appropriate health care professionals.

C. The AdSS must share, with other entities providing services to that member, the results of its identification and assessment of that member's needs.

D. For members requiring a specialized course of treatment or regular care monitoring, the AdSS must have procedures in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

Coordination of Urgent Response for Children Involved With DCS

When a child is removed from his/her home, to the protective custody of the Department of Child Safety (DCS), the AdSS must consider this to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The urgent response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

In cases where DCS notifies the AdSS within five days of physical removal of the child, the AdSS must implement the urgent response process within 72 hours from initial contact by

DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. If notification is received after the fifth day of removal, the AdSS, in collaboration with the DCS Specialist, has the discretion to initiate an urgent response or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services through the Arizona Department of Health Services (ADHS) Behavioral Health System, the Children's Rehabilitative Services (CRS) Contractor may authorize continued services with the behavioral health provider that has established a treatment relationship with the child until a safe transition to a contracted behavioral health provider can be completed.

The urgent response process must include:

A. Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, current disposition of siblings, any known needs of the new caregiver, etc.

B. Conduct a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child's removal.

C. Stabilization of behavioral health crises and offering of immediate services.

D. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term.

E. The provision of needed behavioral health services to the child's caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health provider network.

F. Provide the DCS Case Manager and DDD Support Coordinator with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child's removal.

G. If the child is placed with temporary caregivers, services should support the child's stability by addressing the child's behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child's life. Transitions may include changes in placement, educational setting, and/or reaching the age of majority.

541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

REVISION DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-761 et seq, A.R.S. § 15-1181, A.R.S. § 8-271-273, Division Medical Policy 541

PURPOSE

This policy outlines how the Division's Administrative Services Subcontractors (AdSS) develop and maintain collaborative relationships with other government entities that deliver services to Members and their families, ensuring access to services, and coordinating care with consistent quality.

DEFINITIONS

1. **"**Adult Recovery Team" or "ART" means a group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and service delivery. At a minimum, the team consists of the Member, the Member's Responsible Person, advocates (if assigned), and a qualified behavioral health representative. The team may also include the

enrolled Member's family, physical health, behavioral health or social service providers, the support coordinator, other agencies serving the Member, professionals representing various areas of expertise related to the Member's needs, or other Members identified by the enrolled Member.

2. “Child and Family Team” or “CFT” means a defined group of individuals that includes, at a minimum, the child and his or her family or Responsible Person, the assigned support coordinator, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, or other places of worship and faith, agents from other service systems like Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is

needed to develop an effective Planning Document, and can therefore expand and contract as necessary to be successful on behalf of the child.

3. “Member” means the same as “Client” as defined in A.R.S. § 36-551.

4. “Rapid Response'' means a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is dispatched within 72 hours, to assess a child’s immediate behavioral health needs, and refer for further assessments through the behavioral health system when a child first enters into DCS custody.

5. “Responsible Person” means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

6. “Service Plan” means a complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care

coordination activities, and strategies to assist the Member in achieving an improved quality of life.

7. "State Placing Agency" means the Department of Juvenile Corrections, Department of Economic Security (DES), Department of Child Safety (DCS), the Arizona Health Care Cost Containment System (AHCCCS), or the Administrative Office of the Court. (A.R.S. §15- 1181(12).

8. **"**Team Decision Making" or "TDM**"** means an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child's safety and where they will live.

POLICY

A. COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

1. The AdSS shall develop policies, protocols, and procedures that describe how the AdSS coordinates and manages Member care with other governmental entities.

2. The AdSS shall ensure collaboration through involving other

government agencies to participate in the Member's:

a. Planning Team

b. Child and Family Team (CFT)

c. Adult Recovery Team (ART)

3. The AdSS shall ensure all required protocols and agreements with state agencies are specified in provider manuals.

4. The AdSS shall develop and maintain mechanisms and processes to identify barriers to timely services for Members served by other governmental entities.

5. The AdSS shall work collaboratively to remove barriers to Member care and to resolve any quality of care concerns.

B. ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)

1. The AdSS shall work in collaboration with DCS as outlined below:

a. Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS, including support to providers for awareness and adherence to A.R.S. § 8-271-273;

b. Coordinate development of the Service Plan with the DCS case plan to avoid redundancies and inconsistencies;

c. Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings;

d. Ensure a behavioral health assessment is performed that identifies the behavioral health needs of the child, the child's parents, and family or caregivers, that is based on the Arizona Vision - 12 Principles as specified in AMPM Policy 100;

e. Provide necessary behavioral health services, including support services to caregivers, based on needs identified within the behavioral health assessment and service plan;

f. Engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the CFT;

g. Attend team meetings such as Team Decision Making

(TDM) providing input about the child and family's behavioral health needs.

h. Combine the TDM and CFT meetings, when it is possible;

i. Coordinate behavioral health services in support of family reunification or other permanency plans identified by DCS;

j. Coordinate activities and service delivery that supports the CFT ServicePlan and facilitates adherence to the timeframes established in the following:

i. AdSS Operations Manual Policy 417,

ii. AdSS Operations 449,

iii. AHCCCS Behavioral Health System Practice Tools: AMPM Chapter 200

k. Coordinate activities including coordination with the adult service providers rendering services to adult family members.

2. The AdSS shall coordinate with a Tribal Regional Behavioral Health Authority (TRBHA) for Members receiving behavioral

health services through a TRBHA.

3. The AdSS shall consider the removal of a child from the home to the custody of the DCS to be an urgent behavioral health situation.

4. The AdSS shall consider any child who has experienced a removal by DCS to be at risk for negative emotional consequences and future behavioral health disorders.

5. The AdSS shall implement the Rapid Response process to identify the immediate behavioral health needs of children and address the trauma of the removal itself as outlined below:

    a. The AdSS shall implement the Rapid Response process within 72 hours from initial contact by DCS, in all cases where DCS notifies the AdSS of physical removal of the child, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child.

    b. The AdSS shall collaborate with the DCS Specialist to initiate a Rapid Response when a notification is received

after 72 hours of removal as outlined below:

i. The AdSS shall identify if the DCS Specialist or another entity has referred the child for a behavioral health assessment prior to the AdSS receiving notification.

ii. The AdSS shall authorize continued services with the behavioral health provider that has established a treatment relationship with the child, if the the DCS Specialist has initiated behavioral health services prior to the AdSS being notified.

iii. The AdSS shall assist DCS in identifying members already receiving physical and behavioral health services.

c. The AdSS shall ensure the Rapid Response process includes:

i. Contacting the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how, when, and where the removal occurred, any known

medical, behavioral, or special needs of the child, any known medications, any known supports for the child, current disposition of siblings, and any known needs of the new caregiver, and any other information impacting the health of the child or caregiver's ability to support the child;

ii. Conducting a comprehensive assessment identifying immediate safety needs and presenting problems of the child;

iii. Assessing and addressing needs related to trauma, grief and loss;

iv. Conducting an extended assessment period to accurately identify any emerging or developing behavioral health needs that are not immediately apparent following the child's removal;

v. Stabilization of behavioral health crises and offering of immediate services;

vi. The AdSS shall require its Rapid Response providers to distribute the most recent Foster and Kinship Care Resources Packet to the caregivers of children in DCS

out of home dependencies during the Rapid Response visit. The Resource Packet is available on the AHCCCS website.

vii. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term, including need for and information to support initiation of the Intake Assessment and CFT process;

viii. The provision of needed behavioral health services to the child's caregiver.

ix. Guidance about how to respond to the child's immediate needs in adjusting to foster care,

x. Explanation of physical and behavioral health symptoms to watch for and report,

xi. Assistance in responding to any behavioral health symptoms the child may exhibit, and

xii. Identification of contacts within the behavioral health

system;

xiii. Provision to the DCS Specialist of findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child's removal; and

xiv. If the child is placed with temporary caregivers, services shall support the child's stability by addressing the child's behavioral health needs, identifying any risk factors for placement disruption, and anticipating crises that might develop.

xv. Ensure behavioral health services shall proactively plan for transitions in the child's life. Transitions include changes in placement, educational setting, or reaching the age of majority.

C. DCS ARIZONA FAMILIES F.I.R.S.T. (FAMILIES IN RECOVERY SUCCEEDING TOGETHER-AFF) PROGRAM

1. The AdSS shall ensure that behavioral health providers coordinate with parents, Responsible Persons, families, and caregivers referred through the Arizona Families F.I.R.S.T. (AFF)

Program and that the providers participate in the family's CFT and planning team to coordinate services for the family and temporary caregivers.

2. The AdSS shall ensure behavioral health providers coordinate the following:

   a. Accept referrals for Members and families referred through the AFF Program.
   b. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments.
   c. Develop procedures for collaboration in the referral process to ensure effective service delivery through the AdSS behavioral health system.
   d. The AdSS shall ensure substance use disorder treatment for families involved with DCS are family-centered, provide for sufficient support services and shall be provided in a timely manner, as outlined in Section B in this Policy, to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.

D. ARIZONA DEPARTMENT OF EDUCATION (ADE), SCHOOLS, OR OTHER LOCAL EDUCATIONAL AUTHORITIES

1. The AdSS shall work in collaboration with the ADE and assist with resources and referral linkages for children with behavioral health needs.

2. The AdSS shall ensure that behavioral health providers collaborate with schools and help a child achieve success in school as follows:

   a. Work with the school and share information to the extent permitted by law and authorized by the child's parent or Responsible Person. Refer to AdSS Operations Manual Policy 940;

   b. The AdSS shall include information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning process for children who receive special education services.

   c. The AdSS shall ensure the Behavioral health providers participate with the school in developing the child's IEP and

partner in the implementation of behavioral health interventions, ensuring appropriate coordination of care occurs;

d. The AdSS shall ensure the behavior health provider communicates with and involves the DCS Specialist with the development of the IEP for children in the custody of DCS;

e. The AdSS shall ensure behavioral health providers invite teachers and other school staff to participate in the CFT if agreed to by the child and Responsible Person;

f. The AdSS shall ensure behavioral health providers understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;

g. The AdSS shall ensure the behavioral health providers support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973; and

h. The AdSS shall ensure that transitional planning occurs

prior to and after discharge of an enrolled child from any out-of-home placement.

i. The AdSS shall ensure behavioral health providers collaborate with schools to provide the appropriate behavioral health services in school settings, identified as Place of Service (POS) 03 and submit reports as specified in Contract.

j. The AdSS shall not be financially responsible for services provided by Local Educational Authorities (LEAs), as specified in AMPM Policy 710, for Members receiving special education services.

E. ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1. The AdSS shall ensure behavioral health providers coordinate Member care with the Arizona Early Intervention Program (AzEIP). The AdSS shall ensure:

   a. Children birth to three years of age are referred to AzEIP when information obtained in the child's behavioral health assessment reflects developmental concerns,

   b. Children found to require behavioral health services as part

of the AzEIP evaluation process receive appropriate and timely service delivery, and

c. If an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

2. The AdSS shall ensure behavioral health providers work collaboratively with the DES Rehabilitation Services Administration (DES/RSA) with the goal of increasing the number of employed Members who are successful and satisfied with their vocational roles.

F. COURTS AND CORRECTIONS

1. The AdSS shall collaborate,and coordinate care, and ensure that behavioral health providers collaborate and coordinate care for Members with behavioral health needs and for Members involved with:

a. Arizona Department of Corrections (ADOC),

b. Arizona Department of Juvenile Corrections (ADJC),

c. Administrative Offices of the Court (AOC), or

d. County Jails System.

2. The AdSS shall collaborate with courts or correctional agencies to coordinate Member care as outlined in AHCCCS AMPM Policy 1021 and 1022. The AdSS shall:

a. Work in collaboration with the appropriate staff involved with the Member;

b. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with approval from the Responsible Person;

c. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan; and

d. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible Members.

e. Ensure the behavioral health provider manages and coordinates care upon the Member's release.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:58 PDT)
Anthony Dekker, D.O.

542 ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: September 22, 2021
REFERENCES: AMPM Policy 540, Electronic Visit Verification

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and the DD THP providers.

This Policy establishes requirements for Contractors and providers regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. 1396b(l).

DEFINITIONS

Aggregator - A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.

AHCCCS Electronic Visit Verification (EVV) Vendor - The AHCCCS selected Statewide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

Alternate Electronic Visit Verification (EVV) System - Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected Statewide EVV vendor.

Designee - For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.

Direct Care Worker (DCW) - For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.

Electronic Visit Verification (EVV) - A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

Electronic Visit Verification (Evv) System Chapter 500 – Care Coordination Requirements - The AHCCCS procured system or an AHCCCS approved alternate EVV system.

Health Care Decision Maker - An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231, or 36-3281.

Manual Edit - Any change to the original visit data. All edits shall include an appropriate audit trail.

Prior Authorization – For the purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

Service Confirmation - A notification to AHCCCS through an online portal by a provider a service that does not require Prior Authorization will be provided to a member that is medically necessary.

Service Plan - A complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

POLICY

The Division is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. 1396(b)(l). AdSS and providers are required to utilize AHCCCS's single statewide EVV System for data collection or providers may choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS and the Division are using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that will be mandated to use EVV can be found on the AHCCCS website.

A. Service Verification

1. AdSS shall ensure that all providers who are subject to EVV utilize the AHCCCS procured system or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.

3. If a member/Health Care Decision Maker is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/Health Care Decision Maker is required to sign a standardized AHCCCS attestation specified in AHCCCS AMPM 540 Attachment A Designee Attestation form ("Attachment A") found on the AHCCCS website, at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change

decisions about verification delegation at any time by completing a new attestation. The Qualified Vendor shall keep the attestation on file, following the Divisions record retention requirements outlined in the Qualified Vendor Agreement.

4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the Attachment A Designee Attestation form prior to the delegation of service delivery verification responsibility.

5. Neither the Health Care Decision Maker nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or Health Care Decision Maker shall document in Attachment A.

B. Paper Timesheets

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.

2. Individuals for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.

3. Individuals electing not to use other visit verification modalities on the basis of moral or religious grounds.

4. Individuals with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Members who need to have their address and location information protected for a documented safety concern (i.e., witness protection or domestic violence victim or members in the Address Confidentiality Program as outlined in DES Policy VR-2.2-v1).

The member/Health Care Decision Maker and provider are required to sign a standardized AHCCCS attestation as specified in AHCCCS AMPM 540 Attachment B (“Attachment B”) and utilize the standardized paper timesheet specified in AHCCCS AMPM 540 Attachment C (“Attachment C”). Attachment B is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. AdSS must review the records of the provider annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for providers to utilize their own paper timesheet as long as AHCCCS minimum data elements are captured.

The provider shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in ACOM Policy 203 (Claims Processing) or the provider's contract with the AdSS, are also met. The signature does not have to be recorded in the EVV System, but Agencies shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. EVV Modalities

1. The member/Health Care Decision Maker is able to choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. AdSS shall ensure that providers have at least two different types of visit verification modalities available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The AdSS shall ensure that the provider assists the member/Health Care Decision Maker to make an informed decision about the choice of data collection modality. The member/Health Care Decision Maker shall be permitted to change the modality at any time.

2. It is allowable for provider agencies to allow DCWs to utilize personal devices such as a smartphone. The AdSS shall ensure that if the provider elects this option, the provider is responsible to have a back-up plan for EVV if the device becomes inoperable.

3. The AdSS shall ensure that if the provider chooses to allow for GPS tracking while the DCW is on the clock, the provider shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.

4. Members shall be afforded the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. EVV Prior Authorizations and Service Confirmation Portal

Some EVV services require Prior Authorization, and some do not. To ensure all EVV services have an authorization record in the EVV System, AHCCCS has instituted and will require the use of Service Confirmations for EVV services that currently do not require Prior Authorization. Service Confirmation is simply a notification to AHCCCS for any EVV services not Prior Authorized by a provider that a service will be provided to a member that is medically necessary. AHCCCS has created an online web-based Service Confirmation portal for providers to enter the required data for the service (service code, units, and dates of service). The Service Confirmation Portal is available on the AHCCCS website.

The medical necessity determination date is an additional element required for EVV Services on the Prior Authorization or Service Confirmation. The medical necessity

determination date is the date the need for a new service was determined as specified in guidance documents available on the AHCCCS website.

E. Contingency/Back-Up Plan

The AdSS shall ensure that Provider agencies shall use the standardized AHCCCS Contingency/Back-Up Plan form as specified in Attachment D to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the provider is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Provider with the member at least annually, and a current copy provided to the assigned Support Coordinator. In the event a visit is late or missed, the provider is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/Health Care Decision Maker can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference may be applied based upon the service.

F. Reporting

At a minimum, AdSS shall utilize EVV data to monitor and analyze the following to support provider compliance with EVV as well as inform network adequacy and workforce development planning:

1. Member access to care, including:

   a. Late and missed visits and adherence to contingency planning preferences, and

   b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AMPM Policy 1620-A (Initial Contact/Visit Standard), AMPM Policy 1620-D (Placement/Service Planning Standard), AMPM Policy 580 (Behavioral Health Referral and Intake Process), and AMPM Policy 310-B (Title XIX/XXI Behavioral Health Service Benefit).

2. Provider Performance, including:

   a. Unscheduled visits,

   b. Manual Edits,

   c. Device utilization,

   d. EVV modality types in use,

   e. Visits that follow the member's Contingency/Back-Up Plan, and

f. Monitoring of service hours authorized compared to service hours actually provided.

3. The AdSS contracted provider shall self-monitor and analyze the following:

a. Performance, including:

i. Location discrepancies, and

ii. Visit exceptions.

b. Devices

i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider.

c. Service Delivery

i. Monitor service hours authorized compared to service hours actually provided.

G. Provider Requirements and Contractor Oversight

The AdSS shall monitor all provider responsibilities specified in this Policy as part of annual monitoring to ensure compliance for the following roles and responsibilities of providers required to utilize EVV, including but not limited to:

1. Notifying the AHCCCS EVV Vendor of all new users and user terminations and all data security incidents.

2. Collecting and maintaining records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation, paper timesheet allowances, and contingency/back-up plans as specified in this Policy.

3. Counseling the member/Health Care Decision Maker on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.

4. Developing a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in or onsite caregivers.

5. Ensuring that all associated EVV System users have access to training on the EVV System.

6. For providers using an Alternate EVV System, submitting data timely to AHCCCS as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Comply with member responsiveness including requirements that provider agencies shall answer the phone 24/7 or return a phone call within 15 minutes for members who are reporting a missed or late visit.

8. For providers using the AHCCCS procured EVV System, developing and implementing policies to account for and ensure the return of devices issued by providers to DCWs.

9. Ensuring the provider has at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.

10. Ensuring any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.

11. Ensuring any providers that permit DCWs to utilize personal devices, such as a smartphone, have an alternate verification method or option if the device becomes inoperable.

12. Ensuring that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g., landline telephone).

13. Contacting the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements for addendums to records. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

14. Documenting Manual Edits to visits within the system and/or maintaining hard copy documentation.

H. Provider Attestation

The AdSS shall ensure that new providers complete an attestation verifying agreement to comply with the requirements of Electronic Visit Verification. This attestation shall be incorporated as a requirement of the AdSS credentialing process.

560 CRS CARE COORDINATION AND SERVICE PLAN MANAGEMENT

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. 36-2912, A.A.C. R9-22-1303, A.A.C. R9-22-101

This policy applies to the Administrative Services Subcontractors (AdSS).

This policy establishes requirements regarding Children's Rehabilitative Services (CRS) care coordination for ALTCS members designated as having a CRS condition and defines the process for development and management of the member's service plan.

The AdSS is responsible for ensuring that:

- Every member has a Service Plan initiated upon notice of enrollment; and updating the Service Plan as the member's health condition or treatment plans change.
- Care is coordinated according to the Service Plan and in cooperation with other State Agencies, AHCCCS Contractors, or Fee-For-Service (FFS) programs with which the member is enrolled, and Community Organizations.

AHCCCS identifies members who meet a qualifying condition(s) for CRS and who require active medical, surgical, or therapy treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-22-1303. The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the determination process. DMS may also provide information received for purposes of a CRS designation regarding care, services or procedures that may have been approved or authorized by the member's current health plan or FFS program.

Service delivery must be provided in a family-centered, coordinated and culturally competent manner in order to meet the unique physical, behavioral and holistic needs of the member.

Members with a CRS designation may receive care and specialty services from an MSIC or community based provider in independent offices that are qualified to treat the member's condition. The AdSS must ensure availability of alternative methods for providing services such as field clinics and telemedicine in rural areas.

The AdSS must ensure the development and implementation of a Service Plan for members designated as having a CRS Condition and are responsible for coordination of the member's health care needs and collaboration as needed with providers, communities, agencies, service systems, and members/guardians/designated representatives in development of the Service Plan.

The AdSS must ensure the Service Plan is accessible to all service providers and contains the behavioral health, physical health, and administrative information necessary to monitor a coordinated and integrated treatment plan implementation.

Definitions

A. Active Treatment - a current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care

provider.

B. CRS Condition - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

C. Designated Representative - parent, guardian, relative, advocate, friend, or other person, designated in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs. See A.A.C. R9-22-101.

D. Field Clinic - "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

E. Multi-Specialty Interdisciplinary Clinic (MSIC) - established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

F. Multi-Specialty Interdisciplinary Team (MSIT) - team of specialists from multiple specialties who meet with members and their families for the purpose of determining an interdisciplinary treatment plan.

G. Service Plan - complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Care Coordination

The AdSS must establish a process to ensure coordination of care for members that includes:

A. Coordination of member health care needs through a Service Plan

B. Collaboration with members/guardians/designated representatives, other individuals identified by the member, groups, providers, organizations and agencies charged with the administration, support or delivery of services that is consistent with federal and state privacy laws

C. Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements or makes the decision to transition to another Division Contractor after the age of 21 years

D. Service coordination to ensure specialty services related to a member's CRS condition(s) care completed, as clinically appropriate prior to the member's 21st birthday. Appropriate service delivery and care coordination must be provided regardless of the member's CRS designation ending.

Service Plan Development and Maintenance

A. The AdSS is responsible for ensuring that:

- Each member designated to have a CRS Condition has a member-centric Service Plan and that the member's first provider visit occurs within 30 days of designation.
- Services are provided according to the Service Plan.

The Service Plan serves as a working document that integrates the member's multiple treatment plans, including behavioral health, into one document in a manner and format that is easily understood by the member/guardian/designated representative, and shared with the member/guardian/designated representative upon request or as part of the Multi-Specialty Interdisciplinary Team (MSIT), Child Family Team (CFT), or Adult Recovery Team (ART) meetings. The Service Plan identifies desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives. The Service Plan must identify the immediate and long-term healthcare needs of each newly enrolled member and must include an action plan. The AdSS is responsible for ensuring that every member has an initial Service Plan developed by the AdSS within 14 days of the notice of designation utilizing information provided by AHCCCS DMS. The Service Plan must be monitored regularly and updated when there is a change in the member's health condition, desired outcomes, personal goals or care objectives.

B. A comprehensive Service Plan must be developed within 60 calendar days from date of the first appointment for the CRS qualifying condition and must include, but is not limited to, all the following required elements:

a. Member demographics and enrollment data

b. Medical diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies

c. Action plan

d. The member's current status, including present levels of functioning in physical, cognitive, social, behavioral, and educational domains

e. Barriers to treatment, such as member/guardian/designated representative's inability to travel to an appointment

f. The member/guardian/designated representative's strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the member

g. Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes.

C. The AdSS must identify an interdisciplinary team to implement and update the Service Plan as needed.

D. The AdSS must modify and update the Service Plan when there is a change in the member's condition or recommended services. This will occur periodically as determined necessary by the member/guardian/designated representative, or provider(s).

E. The AdSS must identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur, and who identifies organizations and providers with whom treatment must be coordinated.

Specialty Referral Timelines

The AdSS must have a policy and procedure that ensures adequate access to care through scheduling of appointments as specified in ACOM Policy 417.

570 BEHAVIORAL HEALTH PROVIDER CASE MANAGEMENT

EFFECTIVE DATE: November 9, 2022
REFERENCES: A.R.S § 36-551; ACOM 407; AMPM Chapter 200; AMPM 320-O; AMPM 570; AMPM 570 Attachment A

PURPOSE

The purpose of this policy is to outline the requirements for Behavioral Health Provider Case Management services for Administrative Services Subcontractors (AdSS) whose contract includes this service.

DEFINITIONS

1. "Assertive Community Treatment Case Management" focuses upon members with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems.
2. "CALOCUS" is a standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family, and guides provision of ongoing service planning and treatment outcome monitoring in all clinical and community-based settings.

3. "Connective Case Management" means to focus upon members who have largely achieved recovery and who are maintaining their level of functioning. Connective case management involves careful monitoring of the member's care and linkage to service. Caseloads may include both members with an SMI designation as well as members with a general mental health condition or Substance Use Disorder as clinically indicated.
4. "High Needs Case Management" means focus upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvement for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require to be offered the assignment of a high needs case manager are identified as:
    a. Children 0 through five years of age with two or more of the following:
        i. Involvement with Arizona Early Intervention Program (AzEIP), Department of Child Safety (DCS), and/or Division of Developmental Disabilities (DDD), and/or

ii. Out of home residential services for behavioral health treatment within past six months, and/or

iii. Utilization of two or more psychotropic medications, and/or

iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and

b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.

5. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

6. "Provider Case Management" means a collaborative process provided by a behavioral health provider which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

7. "Provider Case Manager" means the person responsible for locating, accessing, and monitoring the provision of services to clients in conjunction with a clinical team.
8. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a client or an applicant for whom no guardian has been appointed.
9. "Substance Use Disorder" means a range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
10. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551
11. "Supportive Case Management" means focus upon members for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include members with an

SMI designation as well as members with a general mental health condition or substance use disorder as clinically indicated.

POLICY

A. The AdSS shall provide Provider Case Management services concurrently with DDD support coordination when the member/responsible person requests them and when determined medically necessary to coordinate services.

B. The AdSS shall cover case management services provided by behavioral health providers involved with a member's care outside of the role of an assigned behavioral health case manager. The AdSS shall refer to the Arizona Health Care Cost Containment System (AHCCCS) Behavioral Health Services Matrix for billing and coding requirements for case management services.

C. The AdSS shall ensure that Provider Case Managers monitor the member's current needs, services, and progress through regular and ongoing contact with the member/responsible person.

D. The AdSS shall ensure that the frequency and type of contact for case management services are determined by the Child and Family Team (CFT) or Adult Recovery Team (ART) during the treatment planning

process, and adjusted as needed, considering clinical need and member preference.

E. The AdSS shall ensure that one of the following intensity levels for Provider Case Management services is determined by the CFT or ART:

1. Connective Case Management
2. Supportive Case Management
3. High Needs Case Management
4. Assertive Community Treatment Case Management

F. The AdSS shall ensure that Provider Case Managers coordinate care on behalf of DDD members and ensure they receive the treatment and support services that will most effectively meet the member's needs by:

1. Coordinating with the member/responsible person, social rehabilitation, vocational/employment and educational providers, supportive housing and residential providers, crisis providers, health care providers, peer and family supports, other state agencies and natural supports as applicable.
2. Obtaining input from providers and other involved parties in the assessment and service planning process.

3. Providing coordination of the care and services specified in the member's service plan and each provider/program's treatment plan, to include physical and behavioral health services and care.
4. Obtaining information about the member's course of treatment from each provider at the frequency needed to monitor the member's progress.
5. Participating in all provider staffing and treatment/service planning meetings.
6. Obtaining copies of provider treatment plans and entering as part of the medical record.
7. Providing education and support to members/responsible persons, family members, and significant others regarding the member's diagnosis and treatment with the member/responsible person's consent.
8. Providing a copy of the member's behavioral health service/treatment plan to other involved providers and involved parties with the consent of the member/responsible person's consent.

9. Providing medication and laboratory information to residential and independent living service providers or other caregivers involved with the consent of the member/responsible person.
10. Coordinating care with the member's assigned care manager as applicable.
11. Utilizing the Behavioral Health Practice Tools located in AMPM Chapter 200 for children.
12. In crisis situations:
    a. Identifying, intervening, and/or following up with a potential or active crisis situation in a timely manner,
    b. Providing information, backup, and direct assistance to crisis and emergency personnel, including "on-call" availability of case manager or case management team to the Crisis System
    c. Providing follow-up with the member/responsible person after crisis situations, including contact with the member within 24 hours of discharge from a crisis setting,

d. Assessing for, providing, and coordinating additional supports and services as needed to accommodate the member's needs, and

e. Ensuring the member's annual crisis and safety plan is updated as clinically indicated, based on criteria as specified in AMPM Policy 320-O, and readily available to the crisis system, clinical staff and individuals involved in development of the crisis and safety plan.

G. The AdSS shall develop a provider network with a sufficient number of qualified and experienced Provider Case Managers who are available to provide case management services to all enrolled members and shall meet the caseload ratios as specified in Attachment A except as otherwise specified and approved by AHCCCS.

H. The AdSS shall ensure that all children receiving behavioral health services and DDD members with a Serious Mental Illness (SMI) designation are assigned to a case manager in accordance with A.A.C. R9-21-101, and that all other members are assigned a Provider Case Manager as needed, based upon a determination of the member's service acuity needs.

I. The AdSS shall ensure that providers orient new case managers to the fundamentals of providing case management services, evaluate their competency to provide case management, and provide basic and ongoing training in the specialized subjects relevant to the populations served by the provider, and as specified in ACOM Policy 407.

J. The AdSS shall ensure that the behavioral health provider provides accurate contact information for the Provider Case Manager and AdSS for assistance. The AdSS shall also require that behavioral health providers provide accurate information to the member/responsible person for what to do in cases of emergencies and/or after hours.

K. The AdSS shall ensure that providers have a system of back-up case managers in place for members who contact an office when their assigned case manager is unavailable and that members be given the opportunity to speak to the back-up case manager for assistance.

L. The AdSS shall ensure behavioral health providers respond to members/responsible person's messages left for case managers within two business days.

M. The AdSS shall ensure that Provider Case Managers are not assigned duties unrelated to member specific case management for more than

10% of their time if they carry a full caseload as specified in AMPM 570 Attachment A.

N. The AdSS shall ensure that providers establish a supervisor to case manager ratio that is conducive to a sound support system for case managers as per AMPM 570 Attachment A, including establishing a process for reviewing and monitoring supervisor staffing assignments in order to adhere to the AdSS's designated supervisor to case manager ratio.

O. The AdSS shall ensure that Provider Case Manager supervisors have adequate time to train and review the work of newly hired case managers and to provide support and guidance to established case managers.

P. In order to prevent conflicts of interest, the AdSS shall ensure that a Provider Case Manager is not:

1. Related by blood or marriage or other significant relation to a member or to any paid caregiver for a member on their caseload.
2. Financially responsible for a member on their caseload.

3. Empowered to make financial or health-related decisions on behalf of a member on their caseload.
4. In a position to financially benefit from the provision of services to a member on their caseload.
5. A provider of paid services (e.g., Home and Community Based Services (HCBS), privately paid chores, etc.) for any member on their caseload.

Q. The AdSS shall establish and implement mechanisms to promote coordination and communication between Provider Case Management and AdSS care management teams, with particular emphasis on ensuring coordinated approaches with the AdSS's Chief Medical Officer (CMO), Medical Management (MM) and Quality Management (QM) teams as appropriate.

R. The AdSS shall submit, as specified in contract, a Case Management Plan that addresses how the AdSS will implement and monitor case management standards and caseload ratios for adult and child members. The Case Management Plan shall also include performance outcomes, lessons learned, and strategies targeted for improvement. Following the initial submission, subsequent submissions shall include

an evaluation of the AdSS's Case Management Plan from the previous year.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 12:40 PDT)
Anthony Dekker, D.O.

580 BEHAVIORAL HEALTH REFERRAL AND INTAKE PROCESS

REVISION DATE: 6/15/2022, 8/04/2021

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS), whose contract includes this requirement, and describes the behavioral health referral requirements for Title XIX eligible members, enrolled in a DDD Health Plan, to ensure members with behavioral health and substance use disorders can gain prompt access to behavioral health services.

DEFINITIONS

Assessment means the ongoing collection and analysis of a member's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the member's planning document is designed to meet the member's (and family's) current needs and long-term goals.

Intake means the initial evaluation and collection, by appropriately trained staff, of basic demographic information and preliminary identification of the member's needs.

Referral means, for purposes of this Policy, a verbal, written, telephonic, electronic, or in-person request for behavioral health services.

Responsible Person means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S § 36-551

Serious Mental Illness (SMI) Determination means a determination as to whether an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

POLICY

A. GENERAL REQUIREMENTS FOR BEHAVIORAL HEALTH SERVICES REFERRAL

1. A referral may be made, but is not required, to initiate behavioral health services.
2. A member/responsible person may directly outreach a behavioral health provider, the Division or the AdSS to initiate services or to identify a contracted service provider. If behavioral health services are not available within the service array of an existing provider, a referral may be made by any of the following:
    a. A member or the member's responsible person,
    b. The Division,
    c. The AdSS,
    d. Primary care provider (PCP) (The AdSS shall ensure training and education is provided to the PCPs regarding

the behavioral health referral process.),

e. Other providers within their scope of practice,

f. Hospital,

g. Jail,

h. Court,

i. Probation or parole officer,

j. Tribal entity,

k. Indian Health Services/638 Tribally operated facility,

l. School,

m. Other governmental or community agency, and

n. Members in the legal custody of the DCS, the out-of-home placement as specified in A.R.S. §8-512.01 and AdSS Operations Policy 449.

3. To facilitate a member's timely access to behavioral health services, the AdSS shall ensure an effective referral process is in place for members seeking or screened as at-risk for needing behavioral health services, including but not limited to General Mental Health/Substance Use Services, members determined to have an SMI designation, and those seeking an SMI designation. This process shall include:

   a. Engaging with the member/responsible person to communicate the process for making referrals, including self-referrals, ensuring that the referral process maximizes member and family voice and choice of service providers;

b. Referrals are accepted for behavioral health services 24 hours a day, seven days a week. The processing of referrals shall not be delayed due to missing or incomplete information. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

c. Sufficient information is collected through the referral process to:

- Assess the urgency of the member's needs.
- Track and document the disposition of referrals to ensure subsequent initiation of services. The AdSS shall comply with timeliness standards specified in AdSS Operations Policy 417.
- Ensure members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs.

d. Information or documents collected in the referral process are kept confidential and protected in accordance with applicable federal and state statutes, regulations, and policies.

f. Providers shall offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

4. The provider directory shall be maintained in accordance with Division Operations Policy 406 and shall indicate which providers are accepting referrals. Providers shall promptly notify the AdSS of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

B. REFERRALS FOR INDIVIDUALS ADMITTED TO A HOSPITAL

1. The AdSS provider shall ensure referrals involving members admitted to a hospital, who are identified as in need of behavioral health services are responded to as follows:

   a. Upon notification of a member not currently receiving behavioral services, the AdSS provider shall ensure a referral is made to a provider agency within 24 hours.

   b. The AdSS shall ensure provider agencies attempt to conduct a face-to-face intake evaluation with the individual within 24 hours of referral and the evaluation occurs prior to discharge from the hospital.

   c. For members already receiving behavioral health services, the AdSS shall ensure coordination, transition, and discharge planning activities are completed in a timely manner as specified in Division Medical Policy 1021.

C. DIVISION OVERSIGHT OF AdSS

1. The AdSS shall comply with the Division oversight activities including, but not limited to the following methods to ensure compliance with this policy and policies referenced within:

a. Annual Operational Review of related standards, including but not limited to:

i. The AdSS has policies and procedures to ensure members receive behavioral health services.

ii. The AdSS ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.

iii. The AdSS ensures that training and education is provided to PCPs regarding the behavioral health referral process.

iv. The AdSS informs PCPs of the ability and process to directly refer members with suspected diagnosis of autism or other DDD eligible diagnoses directly to a specialized Autism Spectrum Disorder, Cognitive/ Intellectual Disability or other DDD qualifying diagnosing provider. For the purpose of eligibility, refer to the Division's Eligibility Policies 200-G and 200-H for a list of diagnostic and functional criteria.

v. The AdSS documentation reflects evidence that medically necessary behavioral services were determined by a qualified behavioral health professional.

2. Submit deliverable reports or other data as required.

3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:44 PDT)

Anthony Dekker, D.O.

590 BEHAVIORAL HEALTH CRISIS SERVICES AND CARE COORDINATION

EFFECTIVE DATE: December 7, 2022
REFERENCES: AHCCCS Contract; AHCCCS Medical Policy Manual 590

PURPOSE

This policy describes the requirements related to the behavioral health Crisis system for Arizona Long Term Care System (ALTCS) eligible members. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Crisis" means an acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. A Crisis is self-defined and determined by the individual experiencing the situation. An individual is in Crisis if the individual finds they lack the skills or are unable to cope with a situation or event that is impacting them.
2. "Crisis Services" means services that are community based, recovery-oriented, and member-focused that shall work to

stabilize members as quickly as possible so as to assist them in returning to their baseline of functioning.

POLICY

A. The AdSS shall coordinate and cover medically necessary services and care provided to members after the initial 24 hours of a Crisis episode or discharge from a Crisis stabilization setting, whichever occurs first.

B. The AdSS shall cover all emergency transportation and non-emergent transportation from Crisis receiving facilities.

C. The AdSS shall publicize Crisis Services, including the statewide Crisis phone number, prominently on their websites, in their resource directories, and on relevant member and community materials as specified in AHCCCS Contractor Operations Manual (ACOM) Policies 404, 406, and 433.

D. The AdSS shall ensure the behavioral health provider coordinates post-Crisis care and service delivery when an enrolled member engages in Crisis Services.

E. The AdSS shall ensure care coordination occurs between:

1. The member's health plan;

2. Behavioral health provider;
3. The Division;
4. Crisis providers; and,
5. Tribal Regional Behavioral Health Authority (TRBHA) serving the member, if applicable.

F. The AdSS shall develop policies establishing post-Crisis care coordination expectations that provide the following:

1. Transfer of medical records of services received during a Crisis episode, including prescriptions.
2. Tracking of admission, discharge, and re-admissions, including admission setting.
3. Requirements for follow-up directly with the individual, within 72 hours, when discharged from a Crisis setting.
4. Engagement of peer and family support services when responding to post-Crisis situations.
5. The provision of ongoing care is done in an expedient manner in accordance with ACOM Policy 417.

G. The AdSS shall regularly evaluate post-Crisis care coordination activities and work to improve internal and external collaboration efforts. Care coordination activities shall include use of Health Information Technology, as available, to improve member outcomes.

Signature of Chief Medical Officer: Anthony Dekker (Nov 29, 2022 09:23 MST)
Anthony Dekker, D.O.

670 FEDERALLY QUALIFIED HEALTHCARE CENTERS AND RURAL HEALTH CLINICS REIMBURSEMENT

EFFECTIVE DATE: October 1, 2019

PURPOSE: To establish requirements for Administrative Services Subcontractors regarding reimbursement for case management, behavioral health group therapy, Telehealth and Telemedicine services for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

DEFINITIONS:

Behavioral Health Technician, as specified in AAC R9-10-101, an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
2. Are provided with clinical oversight by a behavioral health professional.

Case Management means services furnished to assist members, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, and does not include the direct delivery of underlying medical, educational, social, or other services in accordance with 42 CFR §441.18.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), for purposes of this policy, are reimbursed under the same methodology. An FQHC is a provider who is registered with AHCCCS as provider type C2 or C5. An RHC is a provider who is registered with AHCCCS as provider type 29. This Policy does not apply to any other provider or under any other circumstances.

FQHC/RHC Services, for purposes of this policy, the services of specific licensed professionals, services provided incident to those professional services, and any other ambulatory services offered by the FQHC/RHC that are otherwise included in the State Medicaid Plan.

FQHC/RHC Visit is a face-to-face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline (i.e., dental, physical, behavioral health) or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed

separately.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (e.g., medical supplies, venipuncture, assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (e.g., x-ray, medication, laboratory test).

Prospective Payment System (PPS) Rate, for purposes of this policy, an all-inclusive per visit rate for reimbursing FQHC/RHC services.

POLICY

A. FQHC/RHC Reimbursement for Case Management (T1016)

1. Case Management is not an FQHC/RHC visit reimbursable at the all-inclusive per visit PPS rate. Case Management (T1016) is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice.

2. FQHCs/RHCs are entitled to reimbursement at the all-inclusive per visit PPS rate for encounters that meet the definition of "FQHC/RHC visit."

3. Provider Case Management is not a reimbursable service for Tribal ALTCS. This service is provided through the Tribal ALTCS Programs.

B. FQHC/RHC Reimbursement for Behavioral Health Technician Provided Services

Excluding case management, the services of a BHT may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X.

C. Behavioral Health Group Therapy/Group Services

Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter; therefore, these services are not reimbursable at the all-inclusive per visit PPS rate.

D. Telehealth and Telemedicine for FQHC/RHC Service

Telehealth and Telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AdSS Medical Policy 320-I.

For additional information regarding FQHC/RHC reimbursement, refer to AHCCCS Fee- For-Service Provider Manual, Chapter 10 addendum. For Provider Type C5, refer to AHCCCS IHS/Tribal Provider Billing Manual Chapter 20.

910 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM SCOPE

REVISION DATE: 10/11/2023, 12/07/2022, 10/01/2020, 8/1/2018, 7/15/2016

EFFECTIVE DATE: May 27, 2016

REFERENCES: 42 CFR Part 438, 42 CFR 438.2, 42 CFR 438.208, 42 CFR 438.242, 42 CFR 438.310(c)(2), 42 CFR 438.320, 42 CFR 438.330 AMPM 910

PURPOSE

This policy applies to the Administrative Services Subcontractors' (AdSS) and establishes the requirements regarding the scope, administration, management, and implementation of the Quality Management and Performance Improvement (QM/PI) Program. This policy sets forth roles and responsibilities of the Division to provide oversight and ongoing Evaluation of the Administrative Services Subcontractors' (AdSS) compliance with QM/PI Program requirements.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:
    a. Claims processing, including pharmacy claims,
    b. Pharmacy Benefit Manager (PMB),
    c. Dental Benefit Manager,
    d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),
    e. Management Service Agreements,
    f. Medicaid Accountable Care Organization (ACO),
    g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and
    h. Comprehensive Health Plan (CHP) and DDD Subcontracted Health Plan.

A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Corrective Action Plan" or "CAP" means a written work plan that identifies the root cause(s) of a deficiency. The CAP is made up of goals and objectives; actions and tasks to be taken to facilitate an expedient return to compliance; methodologies to be used to accomplish CAP goals and objectives; and staff responsible to carry out the CAP within the established timelines.
3. "Evaluation" or "Evaluating" means the process used to examine and determine the level of Quality or the progress toward improvement of Quality and performance related to Division service delivery systems.
4. "Health Information System" means the data system that collects, analyzes, integrates, and reports data and can achieve the objectives of 42 CFR Part 438. The system provides information in the following areas: utilization; claims; grievances

and appeals; and disenrollments for other than loss of Medicaid eligibility (42 CFR 438.242).

5. "Long Term Services and Supports" or "LTSS" means services and supports provided to Members of all ages who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider- owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).
6. "Member" means the same as "Client" as defined in A.R.S.§36-551.
7. "Monitoring" means the process of auditing, observing, Evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
8. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from

health care or supportive services (42 CFR 438.320).

9. "Performance Improvement Project" or "PIP" means a planned process of data gathering, Evaluation and analysis to determine interventions or activities that are projected to have a positive Outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).

10. "Provider" means any individual or entity that contracts with the AdSS for the provision of covered services, or ordering or referring for those services to Members enrolled in an AdSS' health plan, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

11. "Quality" as it pertains to external review, means the degree to which a contractor described in 42 CFR 438.310(c)(2) increases the likelihood of desired Outcomes of its Members through:

    a. Its structural and operational characteristics.

b. The provision of services that are consistent with current professional, evidenced-based knowledge.

c. Interventions for performance improvement (42 CFR 438.320).

POLICY

A. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM

1. The AdSS's QM/PI Program shall establish and implement a QM/PI Program that includes the following elements:
   a. PIPs,
   b. Collection and submission of performance measurement data,
   c. Mechanisms to detect both under and overutilization of services, and
   d. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.

2. The AdSS's QM/PI program shall also include the following elements for Long-Term Services and Supports (LTSS):
    a. Mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including:
        i. Assessment of Care between care settings; and
        ii. A comparison of services and supports received with those set forth in the Member's treatment or service plan, if applicable, and
    b. Participation in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements of the State for home and community-based waiver programs.

B. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM COMPONENTS

The AdSS shall adhere to the QM/PI Program requirements as specified in Contract and AMPM Chapter 900. As part of the QM/PI Program, the AdSS shall:

a. Demonstrate that Members' rights and responsibilities are defined, implemented, and monitored;

b. Ensure that medical records and communication of clinical information for each Member reflects all aspects of Member care, including ancillary and behavioral health services, as specified in AMPM Policy 940. Supporting policies shall include processes for electronic signatures when electronic documents are utilized;

c. Conduct temporary or provisional, initial, and re-credentialing processes for individual and organizational providers in accordance with the requirements as specified in AMPM Policy 950;

d. Implement a process for tracking and trending Quality of Care (QOC) concerns, service issue resolutions, and grievance and appeals that meets the standards as specified in AMPM Policy 960, 42 CFR 438.400, and 42 CFR 438.242 et seq.;

e. Develop and implement planned activities to meet or exceed AHCCCS-mandated Performance Measure Performance Standards (PMPS), as specified in Contract and required by AMPM Policy 970, and PIP goals, as required by AMPM Policy 980;

f. Implement processes to review and evaluate its quality improvement data for accuracy, completeness, logic, and consistency as well as trend quality improvement data to identify potential areas for improvement;

g. Evaluate performance measure and PIP results based on a number of demographics in order to reduce, to the extent practical, health disparities based on but not limited to age, race, ethnicity, sex, primary language, and disability status;

h. Identify goals or objectives and implement interventions that are meaningful, specific, and applicable to the population(s) served;

i. Ensure and demonstrate ongoing communication and collaboration between the QM/PI Program and other functional areas of the organization;

j. Demonstrate the obtainment and incorporation of input from AHCCCS Members, stakeholders, advocates, and contracted providers in matters related to the QM/I Program activities;

k. Develop and implement a process for monitoring the quality and coordination between physical and behavioral health services. The process shall include procedures utilized to:

i. Ensure timely updates occur between Primary Care Physicians (PCPs) and behavioral health providers regarding a Member's change in health status. The updates shall include, but are not limited to:

1) Diagnosis of chronic conditions;

2) Changes in physical or behavioral health condition or diagnosis;

3) Support for the petitioning process, if applicable;

4) Transition to or from an ACC-RBHA, based on Serious Mental Illness (SMI) designation, when appropriate. This could include transitions for:

a) Qualifying opt-out conditions;

b) Inter-ACC-RBHA transfers across Geographical Service Area (GSA);

c) Intra-ACC-RBHA transfer provider to provider but across county, within same GSA; and

d) All medication prescribed, or changes made in medication or dosage.

l. Promote timely engagement and appropriate service levels for adult Members, as well as enrolled youth and caregivers;

m. Identify, monitor, and implement interventions for High Needs/High Cost (HN/HC) Members to ensure appropriate

and timely service provision for behavioral or physical health needs;

n. Identify protocol or practices to monitor appropriate use of methodologies for screening or identification of high needs adult Members, and maintain policies for monitoring and documentation of ongoing implementation for AHCCCS review;

o. Identify standards for adults with an SMI diagnosis for all levels of service intensity;

p. Establish mechanisms to connect Members and families to family run organizations;

q. Provide training and monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools including Assertive Community Treatment, Supported Employment, Supportive Housing, and Consumer Operated Services;

r. Provide training of clinical and general staff, including front office staff, on eligibility and use of services available for

substance use prevention or treatment through funds available for individuals that are Non-Title XIX/XXI eligible including but not limited to Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funding, as specified in AMPM Policy 320-T1. Promote Evidence Based Practices in Substance Use Disorder (SUD) Treatment Services;

s. Develop a process to identify and refer youth and young adults to the behavioral health system when identified as having a diagnosed SUD;

t. Ensure the implementation and completion of American Society of Addiction Medicine (ASAM) Criteria (most current edition at the time of service) in substance use disorder assessments, service planning, and level of care placement, and monitor fidelity of ASAM implementation in accordance with AHCCCS directed phased in approach;

u. Develop a process to increase and promote physical health care providers' knowledge of health-related topics

including substance use screening, overdose reversal medications, and Medication Assisted Treatment (MAT) options available to Members;

v. Promote suicide prevention, following the Zero Suicide Model, to support the identification and referral of Members in need of behavioral health or crisis services. Promotion and referral shall include, but not be limited to:

i. Community Members;

ii. Physical health providers;

iii. Behavioral health providers;

iv. Interested stakeholders; and

v. Agencies that serve individuals at increased risk for suicide (Veterans, individuals with Posttraumatic Stress Disorder (PTSD), Native Americans, middle aged white males, Members of the Lesbian, Gay, Bisexual and/or Transgender Queer/Questioning (LGBTQ+) community, foster care, those age 65 and older, juvenile justice, and women post-partum).

w. Identify Veteran and service Member enrollment within the behavioral health system and initiate referrals when behavioral health needs are identified;

x. Implement policies and procedures that require individual and organizational providers to report to the proper authorities, as well as the AdSS, incidents of abuse, neglect, injuries (e.g., falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident. Providers shall submit Incident, Accident, and Death reports to the AdSS as specified in 9 A.A.C. 10, AMPM Policy 960, and AMPM Policy 961;

y. Implement policies and procedures that require individual and organizational providers to monitor and trend all suicides or suicides attempts;

z. Implement policies and procedures to ensure that all providers recognize signs and symptoms of suicidal ideation and at-risk behaviors for children and adults

regardless of mental health status. Policies and procedures shall identify requirements for care coordination between behavioral health providers and PCPs or other medical practitioners involved in Member's care in the event that a physical health or behavioral health practitioner witnesses a patient with suicidal ideation, at-risk behaviors or when there is a significant change in either the behavioral or physical health condition of a Member;

aa. Conduct new Member Health Risk Assessment (HRA) within 90 days of the Member's effective enrollment date.

i. The AdSS shall develop and implement a process to ensure that a "best effort" attempt has been made to conduct an initial HRA of each Member's health care needs;

ii. The process shall also address activities to follow up on unsuccessful attempts to contact a Member within 90 days of the effective date of enrollment;

iii. Each attempt shall be documented; and

iv. The AdSS shall develop processes to utilize the results of HRAs to identify individuals at risk for or with special health care needs, and coordinate care (42 CFR 438.208);

1) Refer to AMPM Policy 1620-A and AMPM Exhibit 1620-1 to obtain time frames for which ALTCS case managers shall have an initial contact with newly enrolled ALTCS Members; and

2) Refer to AMPM Policy 580 and ACOM Policy 417 to obtain time frames for which the AdSS shall have initial contact with referred Members for behavioral health services.

bb. Ensure continuity of care and integration of services utilizing:

i. Programs for care coordination that include coordination of covered services with community and social services, generally available through

contracted or non-contracted providers within the AdSS's service area;

ii. Monitoring of referral activities for both the PCP and the behavioral health provider during referral to, coordination of care with, and transfer of care between the PCP and the behavioral health provider;

iii. Monitoring to ensure that when a Member is transitioning from the physical health provider to the behavioral health provider, or vice-versa, that bridge medications are provided as specified in AMPM Policy 310-V and AMPM Policy 520;

iv. Monitoring of PCP's coordination of care with the Behavioral Health Medical Professional (BHMP), when PCPs are providing medical management services for the treatment of mild depression, anxiety, Attention Deficit Hyperactivity Disorder (ADHD), and SUD, or Opioid Use Disorder (OUD) for Members with an SMI designation; Monitoring shall ensure that medication

management by the PCPs is given within the PCP's scope of practice;

v. Monitoring when PCP is providing treatment of mild depression, anxiety, ADHD, SUD, or OUD to ensure that medications are not contraindicated, based on Member's SMI designation or other behavioral health condition and/or functional status;

vi. Monitoring when a PCP is providing medical management services for a Member to treat a behavioral health disorder, and it is subsequently determined by the PCP and AdSS that the Member shall receive care through the behavioral health system for Evaluation or continued medication management services, the AdSS's subcontracted providers shall assist the PCP with the coordination of the referral and transfer of care. The PCP and the involved behavioral health provider shall document

the care coordination activities and transition of care in the Member's medical record;

vii. Utilizing Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), in accordance with A.R.S. § 36-2606;

viii. Monitoring of the behavioral health provider's referral to, coordination of care with, and transfer of care to PCP, as well as usage of Arizona's CSPMP, in accordance with A.R.S. § 36-2606; and

ix. Monitoring of coordination between behavioral health providers and PCPs or other medical practitioners involved in Member's care in the event that a physical or behavioral health practitioner witness a patient with suicidal ideation or at-risk behaviors.

cc. Implement policies and procedures that specify:

i. The process for Members selecting, or the AdSS assigning, a PCP who is formally designated as having primary responsibility for coordinating the

Members overall health care. The PCP shall coordinate care for the Member including coordination with the BHMP or Behavioral Health Professional (BHP); and

ii. Processes for provision of appropriate medication monitoring for Members taking antipsychotic medication (per national guidelines):

1) Monitoring metabolic parameters for lithium, valproic acid, carbamazepine;

2) Renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and involuntary movement disorders;

3) Provision of medication titration according to, drug class requirements and appropriate standards of care:

a) The circumstances under which services are coordinated by the AdSS, the

methods for coordination, and specific documentation of these processes;

b) Specify services coordinated by the AdSS's Disease Management Unit; and

c) The requirements for timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940.

dd. Implement measures to ensure that Members:

i. Are informed of specific health care needs that require follow-up;

ii. Receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

iii. Are informed of their rights and responsibilities including, but not limited to the responsibility to adhere to ordered treatments or regimens.

ee. Develop and implement procedures for Members with special health care needs, as defined in Contract, including:

i. Identifying Members with special health care needs, including those who would benefit from disease management;

ii. Ensuring an assessment by an appropriate health care professional of ongoing needs of each Member identified as having special health care need(s) or condition(s);

iii. Identifying medical procedures, or behavioral health services as applicable, to address or monitor the need(s) or condition(s);

iv. Ensuring adequate care coordination among providers, including but not limited to, other AdSSs or insurers and behavioral health providers, as necessary;

v. Ensuring a mechanism to allow direct access to a specialist as appropriate for the Member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits); and

vi. Implement processes and measures to ensure that Members receive Special Assistance, based on criteria as specified in AMPM Policy 320-R.

ff. Maintain a health information system that collects, integrates, analyzes, validates, and reports data necessary to implement its QM/PI Program (42 CFR 438.242). Data elements shall include:

i. Member demographics and designations (e.g., Children's Rehabilitative Services [CRS]);

ii. Encounter data and provider characteristics;

iii. Services provided to Members; and

iv. Other information necessary to guide the selection of, and meet the data collection requirements for

performance measures, PIPs, and QM/PI Program oversight.

gg. Include requirements, either in Contract or as an extension of the Contract, for practitioners or providers to cooperate with quality improvement activities and allow the AdSS to utilize their performance measure data;

hh. Ensure the following requirements related to data integrity:

i. Information or data received from providers is accurate, timely, and complete;

ii. Reported data is reviewed for accuracy, completeness, logic, and consistency, and the review and Evaluation processes used are clearly documented. Information that is rejected shall be tracked to ensure errors are corrected and the data is resubmitted and accepted; and

iii. Corrective actions are implemented with providers or vendors when data utilized for implementing and

maintaining its QM/PI Program, including data necessary to calculate and report performance measures, received from providers or vendors is not accurate, timely, or complete.

ii. Results of the AdSS's quality improvement data review, analysis, reporting, and Evaluation are shared with AdSS staff and stakeholders with internal corrective actions implemented when self-identified concerns and performance deficiencies are identified.

i. AdSS staff and providers are kept informed of at least the following:

1) QM/PI Program requirements, activities, updates, or revisions;

2) Study and PIP results;

3) Performance measures and results;

4) Utilization data; and

5) Profiling data results.

jj. All Member and provider information are protected by Federal and State law, regulations, or policies is kept confidential; and

kk. Maintenance of records and documentation as required under State and Federal law.

ll. All QM/PI Program Components shall be supported through the development, implementation, and maintenance of policies and procedures. All policies and procedures shall be specific to each line of business.

C. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE STRUCTURE AND OVERSIGHT

1. The AdSS shall administer the QM/PI Program through a clear and appropriate administrative structure that maintains the ultimate responsibility for the QM/PI Program.
2. The AdSS shall ensure the QM/PI Program work resides within the QM/PI Unit and adheres to requirements as specified in Contract and AMPM Chapter 900.

2. The AdSS shall ensure administrative structure for oversight of its QM/PI Program adheres to requirements of this section, which specify the roles and responsibilities of the following:
   a. The governing or policy-making body;
   b. The Chief Medical Officer (CMO) or designated Medical Director and the local Chief Executive Officer (CEO);
   c. The QM/PI Committee;
   d. The Peer Review Committee;
   e. QM/PI Program Staff;
   f. Delegated Entities; and
   g. The AdSS's executive management.
3. The AdSS Governing or Policy Making Body shall oversee and be accountable for the QM/PI Program, as well as review the QM/PI Program Plan, inclusive of the Work Plan and Work Plan Evaluation, and any applicable updates related to changes in the QM/PI Program scope prior to submission to AHCCCS. Changes in the QM/PI Program scope include any alterations made to the AdSS's QM/PI Program structure from one year to the next. This

may also include line of business, population, and geographic service area changes.

5. The Board of Directors, and in the absence of a Board, the executive body, shall review and approve the QM/PI Program Plan, as demonstrated via an attestation of approval by the Board of Directors or executive body.
6. The Board of Directors, and in the absence of a Board, the executive body, formally evaluates and documents the effectiveness of its QM/PI Program strategy and activities, at least annually, as demonstrated via an attestation of approval by the Board of Directors or executive body.
7. The local CMO or designated Medical Director and CEO shall be responsible for the implementation of the QM/PI Program Plan and shall have substantial involvement in the implementation, assessment, and resulting improvement of QM/PI Program activities.
8. The AdSS's CMO or designated Medical Director shall review and sign all QM/PI policies.

9. The AdSS shall have an identifiable and structured local Arizona QM/PI Committee that is responsible for QM/PI Program functions and responsibilities.
    a. At a minimum, QM/PI Committee Membership shall include:
        i. The local CMO or designated Medical Director as the chairperson of the Committee. The local CMO or designated Medical Director may designate the local Associate Medical Director as their designee only when the CMO or designated Medical Director is unable to attend the meeting. The local CEO may be identified as the co-Chair of the QM/PI Committee;
        ii. The QM/PI Manager(s);
        iii. Representation from the functional areas within the organization;
        iv. Representation of contracted or affiliated providers serving AHCCCS Members; and

v. Clinical representatives of both the AdSS and the provider network.

b. The QM/PI Committee shall ensure that each of its Members are aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file or QM/PI Committee sign-in sheets with requirements noted;

c. The QM/PI Committee shall meet at a minimum of quarterly or more frequently, as needed.

i. The frequency of committee meetings shall be sufficient to monitor all program requirements and to monitor any required actions; and

ii. The AdSS shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation.

d. The QM/PI Committee shall review the QM/PI Program objectives, policies, and procedures as specified in Contract and shall update the policies when processes or

activities are changed substantially. The QM/PI policies and procedures, and any subsequent modification to them, shall be available upon request for review by AHCCCS QM or Quality Improvement (QI) Teams;

e. The QM/PI Committee shall:

i. Review, evaluate, and approve any changes to the QM/PI Program Plan;

ii. Develop procedures for QM/PI Program responsibilities and clearly document the processes for each QM/PI Program function and activity;

iii. Develop and implement procedures to ensure that Contractor staff and providers are informed of the most current QM/PI Program requirements, policies, and procedures; and

iv. Develop and implement procedures to ensure that providers are informed of information related to their performance.

f. The QM/PI Committee meeting minutes shall clearly document discussions of the following when deficiencies are noted:

i. Identified issues;

ii. Responsible party for interventions or activities;

iii. Proposed actions;

iv. Evaluation of the actions taken;

v. Timelines including start and end dates; and

vi. Additional recommendations or acceptance of the results, as applicable.

9. The AdSS Peer Review process shall have the purpose of improving the QOC provided to Members by both individual and organizational providers.

a. The AdSS Peer Review scope shall include cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating, physical, or behavioral health care

professional or provider whether delivered in or out of state.

b. The AdSS Peer review shall be defined by specific policies and procedures which shall address the following requirements:

   i. The AdSS shall not delegate functions of Peer Review to other entities;

   ii. The Peer Review Committee shall be scheduled to meet at least quarterly, or more frequently, as needed; and

   iii. Peer review activities may be carried out as a stand-alone committee or in an executive session of the AdSS's QM Committee.

c. The Peer Review Committee shall consist of the following at minimum:

   i. AdSS's local CMO or designated Medical Director as Chair;

ii. Contracted medical providers from the community that serve AHCCCS Members; and

iii. Contracted behavioral health providers from the community that serve AHCCCS Members.

e. The AdSS Peer Review process shall ensure that providers of the same or similar specialty participate in review and recommendation of individual Peer Review cases.

f. The AdSS's Peer Review Committee shall utilize peers of the same or similar specialty through external consultation if the specialty being reviewed is not represented on the AdSS's Peer Review Committee;

g. The AdSS Peer Review Committee Members shall sign, may be an electronic signature, a confidentiality and conflict of interest statement at each Peer Review Committee meeting;

h. The AdSS Committee Members shall not participate in Peer Review activities if they have a direct or indirect interest in the Peer Review Outcome;

i. The AdSS Peer Review Committee shall evaluate referred cases based on all information made available through the QM process;

j. The AdSS Peer Review Committee is responsible for making recommendations to the AdSS's CMO or designated Medical Director.

   i. The Peer Review Committee shall determine appropriate action which may include: peer contact, education, reduced or revoked credentials, limit on new Member enrollment, sanctions, and/or other corrective actions;

   ii. The AdSS CMO or designated Medical Director shall be responsible for implementing the actions. Adverse actions taken as a result of the Peer Review Committee shall be reported to AHCCCS QM Team as specified in contract,

k. The AdSS Peer Review Committee is responsible for making appropriate recommendations to the AdSS's CMO

or designated Medical Director regarding initiation of referrals for further investigation or action to: Division of Child Safety (DCS), Adult Protective Services (APS), Arizona Department of Health Services (ADHS) Licensure Unit, appropriate regulatory agency or board; and AHCCCS.

i. Notification shall occur when the Peer Review Committee determines care was not provided according to the medical community standards.

ii. The AdSS shall submit the report to the regulatory agency as soon as possible, but no later than 24 hours after the determination; and

iii. The report may be submitted verbally or electronically, email or online, as appropriate for the regulatory agency.

l. The AdSS shall develop a process to timely report the concern to the appropriate regulatory agency, including DCS or APS, ADHS, the Attorney General's Office, law

enforcement, Office of Inspector General (OIG), and AHCCCS QM, for further research, review, or action.

i. The AdSS shall submit the report to the regulatory agency as soon as possible but no later than 24 hours of becoming aware of a concern; and

ii. The report shall be submitted verbally or electronically, as appropriate.

m. The AdSS Peer Review Committee policies and procedures shall assure that all information used in the Peer Review process is kept confidential and is not discussed outside of the Peer Review process. The AdSS's Peer Review Committee reports, meetings, minutes, documents, recommendations, and participants shall be kept confidential except for implementing recommendations made by the Peer Review Committee;

n. The AdSS shall make Peer Review documentation available upon request to AHCCCS for purposes of QM, monitoring, and oversight;

o. The AdSS shall maintain High-level Peer Review summaries as part of the original QOC file;

p. The AdSS shall demonstrate:

   i. How the Peer Review process is used to analyze and address clinical issues;

   ii. How providers are made aware of the Peer Review process; and

   iii. How providers are made aware of the procedure for grieving Peer Review findings.

q. Matters appropriate for Peer Review shall include:

   i. Cases where there is evidence of deficient quality,

   ii. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider, facility, or vendor,

   iii. Questionable clinical decisions, lack of care or substandard care,

   iv. Inappropriate interpersonal interactions, unethical behavior, physical, psychological, or verbal abuse,

neglect, and exploitation of a Member or Members, family, staff, or other disruptive behavior demonstrated by a provider,

v. Criminal or felonious actions related to practice,

vi. Issues that immediately impact the Member and that are life threatening or dangerous, and

vii. Issues that have the potential for adverse Outcome.

10. The AdSS QM/PI Program Staffing shall have qualified local personnel to carry out the functions and responsibilities specified in AMPM Chapter 900 in a timely and competent manner. QM/PI Program positions performing work functions related to the Contract shall have a direct reporting relationship to the local CMO or designated Medical Director and the CEO. The AdSS is responsible for Contract performance, whether or not subcontractors or delegated entities are used. As part of the QM/PI Program Staffing requirements, the AdSS shall:

a. Maintain an organizational chart that shows the reporting relationships for QM/PI Program activities and the percent

of time dedicated to the position for each specific line of business:

i. The QM/PI Program organizational chart shall be maintained and demonstrate the current reporting structures, including the number of full time and part time positions, staff names, and responsibilities; and

ii. This chart shall also show direct oversight of QM/PI Program activities by the local CMO or Medical Director.

b. Develop a process to ensure that all staff is trained on the process for referring suspected QOC concerns to the QM Team that shall be provided:

i. During new employee orientation no later than 30 days after the date of hire; and,

ii. At a minimum, annually thereafter.

c. Develop and implement policies and procedures outlining:

i. QM/PI Program staff qualifications including education, certifications, experience, and training for each QM/PI Program position; and

ii. Mandatory QM/PI Program Staff or Management attendance at AHCCCS Contractor meetings unless attendance is specified as optional by AHCCCS.

d. Attend or participate in, and maintain associated documentation for, applicable community initiatives and collaborations as well as implement specific interventions to address overarching community concerns, including, but not limited to:

i. Quality Management and Quality Improvement;

ii. Maternal child health;

iii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Dental;

iv. Chronic Disease management;

v. Long-Term Care;

vi. Behavioral health;

vii. Justice Involvement;

viii. Opioid and substance use;

ix. Suicide;

x. Social determinants of health;

xi. Veterans' resources and services; and

xii. Specific community initiatives and collaborations, and as required by AHCCCS.

e. AHCCCS sponsored activities are not considered community initiatives or collaborations.

11. The AdSS shall oversee Delegated Entities by:

a. Ensuring accountability for all functions and responsibilities delegated to other entities is maintained as specified in AMPM Chapter 900;

b. Ensuring the methodologies for oversight and accountability for all delegated functions be integrated into the overall QM/PI Program, meeting requirements for all delegated functions as specified in AMPM Chapter 900;

c. Including accredited agencies in the AdSS's oversight process;

d. Providing, as a prerequisite to delegation, a written analysis of its historical provision of QM/PI Program oversight function, which includes:

   i. Past goals and objectives; and

   ii. The level of effectiveness of the prior QM/PI Program oversight functions shall be documented.

e. Having policies and procedures requiring that the delegated entity report all allegations of QOC concerns and quality of service issues to the AdSS no later than 24 hours of awareness; QOC or service investigation and resolution processes shall not be delegated;

f. Evaluating the entity's ability to perform the delegated activities prior to delegation. Evidence of such Evaluation includes the following:

   i. Review of appropriate internal areas, such as QM;

ii. Review of policies and procedures and the implementation of them; and

iii. Documented Evaluation and determination that the entity is able to effectively perform the delegated activities.

g. Establishing a written contract, prior to delegation, that:

i. Specifies the delegated activities and reporting responsibilities of the entity to the AdSS; and

ii. Include the AdSS's right to terminate the contract or perform other remedies for inadequate performance.

h. The AdSS shall monitor the performance of the entity and the quality of services provided on an ongoing basis and review annually a minimum of 30 randomly selected cases per line of business for each function that is delegated. Documentation shall be kept on file for Division review. Monitoring shall include, but is not limited to:

i. Utilization;

ii. Member and provider satisfaction;

iii. QOC concerns; and

iv. Complaints.

i. The AdSS shall monitor entities that have been delegated services who are accredited through the National Committee for Quality Assurance (NCQA) or another nationally recognized entity, by reviewing a minimum of 10 randomly selected files per line of business for each function that is delegated. If any issues or concerns are noted within the files reviewed, the Division shall expand the sample to no less than 30 files in order to fully assess and identify issues and implement remediation efforts with the delegated service provider. Monitoring results shall be submitted to AHCCCS in accordance with ACOM Policy 438.

j. The following documentation shall be kept on file and available for Division review:

i. Evaluation reports;

ii. Results of the AdSS's annual monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions;

iii. Corrective Action Plans (CAP)s; and

iv. Appropriate follow up of the implementation of CAPs to ensure that quality and compliance with AHCCCS requirements for all delegated activities or functions are met.

D. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

The AdSS shall develop and implement mechanisms to monitor and evaluate its service delivery system and provider network that demonstrates compliance with all the requirements included within this Policy. Delegated entities conducting monitoring activities shall have direct oversight by the AdSS's QM/PI Program QM staff. QM/PI Program monitoring and Evaluation activities shall include at minimum the following:

1. QM/PI Program scope of monitoring and Evaluation shall be comprehensive. It shall incorporate the activities used by the

AdSS and demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities shall be clearly documented in policies and procedures.

2. If collaborative opportunities exist to coordinate organizational monitoring, the lead AdSS shall coordinate and ensure that all requirements in the collaborative arrangement are met.
3. Monitoring provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in Division and AHCCCS Minimum Subcontract Provisions and Contract.
4. Information and data gleaned from QM/PI Program monitoring and Evaluation that shows trends in QOC concerns shall be used in developing quality improvement initiatives. Selection of specific monitoring and Evaluation activities shall be appropriate to each specific service or site.
5. Development and implementation of methods for monitoring PCP activities related to:

a. Referrals for behavioral health care,

b. Coordination with the behavioral health system (e.g., ACC-RBHAs and behavioral health providers),

c. Transfer of care, when clinically indicated, based on severity of behavioral health need, and

d. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

i. Assurance of communication between prescribers, when controlled substances are used,

ii. Provider-mandated usage of the CSPMP, and

iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing Member satisfaction.

6. Development and implementation of methods for monitoring behavioral health provider activities related to:

a. Referrals for physical health care,

b. Coordination with the physical health system,

c. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

i. Assurance of communication between prescribers, when controlled substances are used,

ii. Include provider-mandated usage of the CSPMP, and

iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing Member satisfaction.

7. Reporting of all QOC concerns including, but not limited to:

a. Incidents of abuse, neglect, exploitation, suicide attempts, opioid-related concerns, alleged human rights violations, and unexpected deaths to the Division QM Team as soon as the AdSS is aware of the incident and no later than one business day, as specified in Contract. The AdSS is expected to investigate and report case findings, including identification of organizational providers, individual

providers, paid caregivers, or the specific individual rendering the service,

b. Identified QOC concerns, reportable incidents, and/or service trends to the Division QM Team immediately upon identification. Reporting shall include trend specifications such as providers, facilities, services, and allegation types,

   i. AdSS QOC trend reports shall be incorporated into monitoring and Evaluation activities and presented to the QM/PI Committee. Policies and procedures shall be adopted to explain how the process is routinely completed.

c. The AdSS is expected to investigate all potential Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC) as QOC concerns within the AHCCCS QM Portal. For more information, refer to AMPM Policy 960.

8. Incorporation of the ADHS licensure and certification reports and other publicly reported data in their monitoring process, as applicable.
9. A process to ensure notification is made to the AdSS's QM clinical staff when a delegated auditing entity identifies either a Health and Safety Concern, Immediate Jeopardy situation, or other serious incident, which impacts the health and safety of a Member. On-site reviews related to Health and Safety Concerns, Immediate Jeopardy situations, or other serious incidents are to be conducted in accordance with the requirements as specified in AMPM Policy 960.
10. The AdSS shall be responsible for ensuring health and safety of Members in placement settings or service sites that are found to have survey deficiencies or suspected issues that may impact the health and safety of AHCCCS Members by:
    a. Participating in both individual and coordinated efforts to improve the QOC in placement settings or service sites; and

b. Utilizing clinical quality staff trained in QOC investigations to conduct on-site reviews if there is a health or safety concern identified either by the AdSS, Division, AHCCCS, or other party.

11. The AdSS QM staff shall conduct the monitoring of services and service sites, in accordance to Attachment A. While the AdSS may also consider incorporating regulatory agency licensing reviews, such as annual inspection surveys, as part of the monitoring of services and service sites, the regulatory agency reviews shall not be used as the sole basis for the entire monitoring Evaluation by the AdSS. Refer to Attachment A for the list of AHCCCS services, service sites, and monitoring frequency.

12. Implementation of policies and procedures for ALTCS Contractors specific to the annual monitoring of attendant care, homemaker services, personal care services, respite services and habilitation services. When deficiencies or potential deficiencies are

identified, they shall be addressed from a Member and from a system perspective.

13. Coordination of mandatory routine quality monitoring and oversight activities for organizational providers, including home and community based service settings, when the provider included is in more than one AdSS network. A collaborative process shall be utilized in counties when more than one AdSS is contracted with and utilizes the facility as specified in Contract.
14. The AdSS, or the lead AdSS, if AdSS collaborative monitoring was completed, shall submit the AdSS monitoring summary to Division QM Team as specified in Contract. Additionally, a standardized and agreed upon tool shall be used and include at a minimum:
    a. General quality monitoring of these services includes, but is not limited to, the review and verification of:
        i. The written documentation of timeliness,
        ii. The implementation of contingency plans,
        iii. Customer satisfaction information,

iv. The effectiveness of service provisions,

v. Mandatory documents in the services or service site personnel file including:

1) Cardiopulmonary resuscitation,

2) First Aid,

3) Verification of skills or competencies to provide care,

4) Evidence that the agency contacted at least three references, one of which shall be a former employer. Results of the contacts shall be documented in the employee's personnel record, and

5) Evidence that the provider conducted the pre-hire and annually thereafter search of the APS Registry as required in Division and AHCCCS Minimum Subcontract Provisions.

b. Specific quality monitoring requirements for ALTCS Contractors are as follows:

i. Direct Care Services, as specified in AMPM Policy 1240-A, Attendant care, Personal Care and Homemaker services, monitoring as specified in Attachment B. Monitoring shall include verification and documentation of all of the following:

1) Mandated written agreement between the Responsible Person, and designated representative and the Direct Care Worker (DCW), as specified in AMPM Policy 1240-A, which delineates the responsibilities of each,

2) Evaluation of the appropriateness of allowing the Member's immediate relatives to provide direct care services,

3) Compliance with ensuring DCWs meet competencies to provide care including training, testing, verifying/sharing of DCW test records and continuing education requirements in accordance with Attachment B. For more

general information on the DCW training and testing standards, as specified in AMPM Policy 1240-A and ACOM Policy 429, and

4) Timeliness and content of supervisory visitations as specified in AMPM Policy 1240- A.

ii. Sampling methodology for monitoring of direct care services shall assure that all provider agencies and all employees have an equal opportunity to be sampled, provider agencies shall be included in the sample frame even if the number of employees does not meet a statistically significant level. All employees shall be included in the sample frame including those who are in the pool of workers but are not currently assigned to a Member,

iii. The AdSS shall monitor that the LTSS services a Member receives align with those that were documented in the Member's LTSS treatment/service plan [42 CFR 438.330 (b)(5)(i)],

iv. The AdSS shall have mechanisms to assess the quality and appropriateness of care provided to Members receiving LTSS services including between settings of care and, as compared to the Member's service plan [42 CFR 438.330 (b)(5)(i)], and

v. The AdSS may also consider incorporating the use of surveys to assess the experience of Members receiving LTSS services as a key component of the AdSS's LTSS assessment process.

Signature of Chief Medical Officer: Anthony Dekker (Oct 4, 2023 16:58 PDT)

Anthony Dekker, D.O.

920 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE REQUIREMENTS

REVISION DATE: 8/16/2023, 4/20/2022, 10/1/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.320, 42 CFR 438.354, 42 CFR 438.358, 42 CFR 438.310(c)(2), 42 CFR Part 457, 42 CFR Part 438, 42 CFR 438.68, 42 CFR 438.206, AMPM Chapter 900; AMPM Policy 910 Attachment A, AMPM Policy 920 Attachment A-B, AMPM Policy 980, Attachment B-D, AMPM Appendix B

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and specifies the Quality Management and Performance Improvement (QM/PI) Program administrative requirements.

DEFINITIONS

1. "Access" means the timely use of services to achieve optimal Outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 and 42 CFR 438.206 (42 CFR 438.320).
2. "Assess or Evaluate" means the process used to examine and determine the level of quality or the progress toward

improvement of quality and performance related to the AdSS service delivery systems.

3. "Corrective Action Plan" or "CAP" means a written Work Plan that identifies the root cause(s) of a deficiency, includes goals and Objectives, actions, or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and Objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and its providers, to enhance Quality Management and Process Improvement activities and the Outcomes of the activities, or to resolve a deficiency.
4. "External Quality Review (EQR)" means the analysis and Evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness, and Access to the health care services that a Contractor or their contractors furnish to Medicaid members [42 CFR 438.320].

5. “External Quality Review Organization (EQRO)” means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, performs EQR, and other EQR- related activities as specified in 42 CFR 438.358, or both [42 CFR 438.320
6. “Measurable” means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive outcome.
7. “Monitoring” means the process of auditing, observing, Evaluating, analyzing, and conducting follow- up activities, and documenting results via desktop or on-site review.
8. “Objective” means a Measurable step, generally one of a series of progressive steps, to achieve a goal.
9. “Outcomes” means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].
10. “Performance Improvement Project (PIP)” means a planned process of data gathering, Evaluation and analysis to determine

interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of Care and service delivery.

11. "Performance Measure Performance Standards (PMPS)" means the minimal expected level of performance by the Division, previously referred to as the Minimum Performance Standard. Beginning in Calendar Year End (CYE 2021, official performance measure results shall be Evaluated based upon the National Committee on Quality Assurance (NCQA) HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services (CMS) Medicaid Median (for selected CMS Core Set-Only Measures), as identified by AHCCCS, as well as the Line of Business aggregate rates as applicable.
12. "Quality" As it pertains to External Quality Review, means the degree to which the AdSS increases the likelihood of desired Outcomes of its members through:
    a. Its structural and operational characteristics.

b. The provision of services that are consistent with current professional, evidenced- based-knowledge.

c. Interventions for performance improvement.

13. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health Outcomes and are consistent with current professionally recognized standards of care and service provision.

14. "Quality Management (QMU) Quality Improvement (QI) Team" means Division staff who Evaluate AdSS Quality Management and Performance Improvement (QM/PI) Programs, monitor, and Evaluate compliance with required quality and performance improvement standards through standardized Performance Measures (PM), Performance Improvement Projects (PIPs), and Quality Improvement specific Corrective Action Plans (CAPs), as well as provide technical assistance for performance improvement related matters.

15. "Work Plan" means a document that addresses all the requirements of AMPM Chapter 900, and AHCCCS-suggested guidelines, as well as supports the Division's QM/PI goals and Objectives with Measurable goals (Specific, Measurable, Attainable, Relevant and Timely (SMART)), timelines, methodologies, and designated staff responsibilities. The Work Plan must include Measurable physical, behavioral, and oral health goals and Objectives.
16. "Work Plan Evaluation" means a detailed analysis of progress in meeting or exceeding the Quality Management and Performance Improvement (QM/PI) Program Objectives, strategies, and activities proposed to meet or exceed the performance standards and requirements as specified in contract and Division Medical Policy Chapter 900.

POLICY

A. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM PLAN

1. The AdSS shall develop a written QM/PI Program Plan that specifies the Objectives of the AdSS QM/PI Program and addresses the AdSS proposed approaches to meet or exceed the performance standards and requirements as specified in the AdSS contract with the Department of Economic Security (DES) under the oversight of the Division and AdSS Medical Policy Chapter 900.
2. The AdSS shall submit the QM/PI Program Planas specified in the Division contract.
3. The AdSS shall include the following in the QM/PI Program Narrative:
    a. Objectives and plans for the upcoming calendar year to meet or exceed the minimum standards and requirements as specified in AdSS contract with the Division and in AdSS Medical Policy Chapter 900.
    b. AdSS activities to identify the needs of its members with Intellectual and Developmental Disabilities (I/DD) and to coordinate care.

c. Follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

d. Description of AdSS participation in community or quality initiatives.

4. The AdSS shall include the following in its QM/PI Program Work Plan Evaluation:

a. Evidence or documentation supporting continued routine Monitoring to Evaluate the effectiveness of the actions and other follow up activities conducted throughout the previous calendar year.

b. Description of how any sustained goals and Objectives shall be incorporated into the AdSS business practice and develop new goals and Objectives once a goal or Objective has been sustained.

c. Performance measure related Plan-Do-Study-Act (PDSA) cycles that have been initiated, updated, or refined as part of the AdSS' ongoing Corrective Action Plan (CAP) Monitoring and Evaluation activities.

d. Goals not met will be addressed and considered for possible internal Performance Improvement Projects (PIPs).

5. The AdSS shall include the following in its QM/PI Program Work Plan:

a. Goals and Objectives that are realistic, Measurable, and based upon established Performance Standards and requirements as specified in the current Division contract and AdSS Medical Policy Chapter 900 when appropriate.

b. Other nationally recognized benchmarks as available to establish the programs minimum performance standards or when performance standards have not been met or when performance standards have not been published by AHCCCS.

c. Strategies and activities to meet or accomplish the identified goals and Objectives.

d. Identify staff positions accountable for meeting the established goals and Objectives.

e. PIPs designed to address opportunities for improvement identified from both external and internal sources.

6. The AdSS shall include the following in its Health Disparity Summary and Evaluation Report:

a. The process utilized to conduct disparity analyses including the analytical tools and the methodology for identifying disparities.

b. Disparity analysis findings associated projects and activities meant to ameliorate the disparity(s) and related Measurable goals and Objectives.

c. An Evaluation of the disparity analysis findings, progress on targeted strategies or interventions, and progress on identified goals and Objectives.

d. A detailed Evaluation of performance measure rates specific to subpopulations.

e. An analysis of the effectiveness of implemented strategies and interventions in meeting the AdSS' health equity goals and Objectives during the previous calendar year.

f. A detailed overview of the AdSS' identified health equity goals and Objectives for the upcoming calendar year to address noted disparities and promote health equity.

g. Targeted strategies or interventions planned for the upcoming calendar year to achieve its goals.

7. The AdSS shall include the following specific to members with I/DD in its Engaging Members Through Technology – Executive Summary:

a. An Evaluation of the previous calendar year's EMTT activities including, but not limited to:

i. The percent of members engaged through telehealth services and through web and mobile- based applications in comparison to total membership, and

ii. Supporting data for member-related Outcomes in comparisons to identified goals and Objectives.

b. Criteria for identifying and targeting members who can benefit from telehealth services and from web and mobile-based applications, including but not limited to:

i. The identification of populations who can benefit from telehealth services to increase Access to care and services, and

ii. The identification of populations who can benefit from web and mobile-based applications.

c. A description of telehealth services and web and mobile-based applications in development and currently being utilized to engage members.

d. Strategies used to engage the identified members in the use of telehealth services and web and mobile- based applications.

e. A description of desired goals and Outcomes for telehealth services and for each web and mobile-based application currently being utilized to engage members, including how the desired outcome will be measured and directly impact the overall quality of and Access to care for the identified population(s).

f. The percent of members anticipated to engage through telehealth services and through web and mobile-based applications during the upcoming calendar year based on the identified strategies and related goals and Objectives.

8. The AdSS shall submit the following referenced or associated Policies to the Division:

   a. New or substantially revised, relevant policies and procedures, referenced in the QM/PI Program Plan Checklist (AMPM Policy 920, QM/PI Program Plan Checklist), are submitted as separate attachments.

   b. Current policies that have not had substantive changes during the year are not required to be submitted in the Plan and will be Evaluated as part of the Division's Operational Review unless submission is seen as a value-add to the QM/PI Program Plan.

9. The AdSS shall submit the QM/PI Program Plan accompanied by a completed AMPM Policy 920, QM/PI Program Plan Checklist.

B. BEST PRACTICES AND FOLLOW-UP ON PREVIOUS YEAR'S EXTERNAL QUALITY REVIEW REPORT RECOMMENDATIONS

The AdSS shall submit recommendations as specified in contract and include:

a. An overview of self-reported best practices submitted as a stand-alone document, highlighting a minimum of three initiatives aimed at improving care and services provided to its members with I/DD.
b. A summary of the AdSS efforts to date in completing the most current and previous year's EQR Report recommendations, as a stand-alone document.
c. Submission of Best Practices and Follow-Up on Previous Year's EQR Report Recommendations Checklist

C. PERFORMANCE MEASURE MONITORING REPORT

1. The AdSS shall submit a report utilizing the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template and AHCCCS Performance Measure Monitoring Report & Work Plan Attachment specifying AdSS' progress in meeting, sustaining, and improving its performance for contractually

required performance measures.

2. The AdSS shall include the following in the Performance Measure Monitoring Report based on the associated reporting period:

   a. The internal rates for each performance measure.

   b. Identified barriers in implementing planned interventions and opportunities for improvement intended to support the AdSS in supporting its identified goals and Objectives.

   c. Detailed analysis of results that includes an Evaluation of AdSS trends in performance compared to the following:

      i. Performance Measure Performance Standards (PMPS) in accordance with AdSS Medical Policy Manual 970.

      ii. AdSS self-identified goals and Objectives.

      iii. Historical performance.

D. PERFORMANCE IMPROVEMENT PROJECT REPORT

1. The AdSS shall submit a Performance Improvement Project (PIP) Report that includes annual updates for both

AHCCCS-mandated and AdSS self-selected PIPs.

2. The AdSS shall comply with the instructions and requirements outlined in AMPM Policy 980, including the use of AMPM Policy 980 Attachment C, Performance Improvement Project (PIP) Report DDD Specific.

E. CORRECTIVE ACTION PLAN

1. The AdSS shall develop and implement a CAP for taking appropriate steps to improve care when issues are identified.
2. The AdSS shall submit all CAPs to the Division for review and approval prior to implementation and shall include:
    a. The concern(s) that require corrective action.
    b. Identification of any deficiency and remedial steps
    c. Documentation of proposed time frames for CAP completion.
    d. Entities responsible for making the final determinations regarding QM/PI Program concerns.
    e. Types of actions to be taken including, but not limited to:

i. Education, training, or technical assistance;

ii. Process, structure, or form changes;

iii. Follow-up Monitoring and Evaluation of improvement as well as implementing new interventions and approaches, when necessary; and

iv. informal counseling.

f. Documentation of performance Outcomes identified barriers, opportunities for improvement, and best practices.

g. Internal dissemination of CAP findings and results to appropriate committees, staff, and network providers.

h. Submission of information to the Division and other stakeholders as required. For Quality of Care (QOC) specific CAPs, information is submitted in accordance with AdSS Medical Policy 960.

3. The AdSS shall submit CAPS as required in AMPM 920, Attachment B, AHCCCS Quality Improvement Corrective Action Plan Proposal Checklist and AHCCCS Quality Improvement Corrective Action Plan Update Checklist.

4. The AdSS shall maintain documentation regarding CAPS development, implementation, performance Outcomes, identified barriers, opportunities for improvement, and best practices.

F. ADSS REPORTING REQUIREMENTS

1. The AdSS shall submit deliverables as specified in the contract between the Division and AdSS.

2. If a time extension is necessary, the AdSS shall submit a formal request in writing before the deliverable due date to the Division's Compliance Department, Quality Management or Quality Improvement team manager, as appropriate to the deliverable.

3. The QM/PI Program administrative deliverables shall be

submitted as specified in the contract between the Division and AdSS and is subject to Division approval. Any significant modifications to the QM/PI Program Plan throughout the year shall be submitted for review and approval prior to implementation.

4. The AdSS QM/PI administrative deliverables and other select deliverable submissions are provided to the Division for submission to the AHCCCS EQRO with AdSS supplied information included within the AdSS's annual EQR Report.

G. ADSS DOCUMENTATION REQUIREMENTS

The AdSS shall maintain records that document QM/PI Program activities. The records shall be made available to the Division, Quality Management or Quality Improvement teams upon request. The required documentation shall include, but is not limited to:

a. Policies and procedures

b. Studies and PIPS

c. All required reports

d. All processes, standards of work, and desktop procedures

e. Meeting agendas, minutes and accompanying documents

f. Worksheets (including, but not limited to, excel spreadsheets, graphs, diagrams, flowcharts)

g. Documentation supporting requested by the EQRO as part of the EQR process

h. Other information and data appropriate to support changes made to the scope of the QM/PI Program.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 10:58 PDT)
Anthony Dekker, D.O.

930 RESERVED

REVISION DATES: 07/29/2020, 10/1/2019
EFFECTIVE DATE: October 1, 2019

940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATE: 9/6/2023, 5/24/2021, 12/23/2020
EFFECTIVE DATE: October 01, 2019
REFERENCES: AMPM Policy 710, A.R.S. §13-3620, A.A.C. R9-10, 9 A.A.C. 22, Article 5, 45 CFR 160, 162, and 164, 42 CFR Part 2, 2.1 – 2.67, 42 CFR 431.300 et seq, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi), 45 CFR 431, 42 U.S.C. §290 dd-2.

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS). This policy establishes requirements for protection of Member information, documentation requirements for Member physical and behavioral health records, and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems.

DEFINITIONS

1. "Adult Recovery Teams" or "ARTs" means A group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and

service delivery made up of the following people:

a. The Member;

b. The Member's Health Care Decision Maker (HCDM) if one is in place;

c. Any assigned advocates;

d. A qualified behavioral health representative; and

e. Other individuals identified by the Member or HCDM such as the Member's family, physical health, behavioral health or social service providers, other agencies serving the Member, and professionals representing various areas of expertise related to the Member's needs.

2. "Arizona Association of Health Plans" or "AzAHP" means an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the contractors with regard

to the behavioral health chart audit process.

3. "Child and Family Teams" or "CFTs" - means a group of individuals made up of the following people:

   a. The child and their family, or HCDM;

   b. A behavioral health representative; and

   c. Any individuals important in the child's life that are identified and invited to participate by the child and family.

4. "Designated Record Set" or "DRS" means a group of records maintained by the Provider that contain the following:

   a. Medical and billing records maintained by a Provider;

   b. Case and medical management records; or

   c. Any other records used by the Provider to make medical decisions about the Member.

5. "Health Information Exchange" or "HIE" means the secure sharing of patient health information among authorized Providers.

   a. HIE is a process or action that can be facilitated by an HIO.

b. Health information exchange can also include the secure sharing of patient health information directly between Providers.

6. “Health Information Organization” or “HIO” means an entity that facilitates the secure exchange of electronic patient health information between participating Providers.

7. “Medical Records” means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers, in both hard copy and electronic form. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 122291.

8. “Member” means the same as “Client” prescribed in A.R.S. § 36.551.

9. “Multi-Specialty Interdisciplinary Clinic” or “MSIC” means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing

interdisciplinary services to treat Members.

10. "Provider" means an individual or organization that contracts with the AdSS for the provision of covered services, or ordering or referring for those services, to eligible Division Members, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall require Providers to maintain comprehensive documentation related to care and services provided to Members.
2. The AdSS shall ensure, via regular monitoring activities, that documentation completed and maintained by the Providers meets the requirements specified in this policy.

B. MEDICAL RECORD REQUIREMENTS

1. The AdSS shall require Providers to maintain the following in their Medical Records:
   a. Up to date, well organized and comprehensive documentation, with sufficient detail to promote effective Member care and ease of quality review.

b. Documentation of the following identifying demographics:

i. The Member's name,

ii. Address,

iii. Telephone number,

iv. AHCCCS identification number,

v. Gender,

vi. Age,

vii. Date of birth (DOB),

viii. Marital status,

ix. Next of kin,

x. Parent, guardian, or healthcare decision maker, if applicable.

c. The following Member identification information on the first page of the Medical Record:

i. Member name,

ii. Member AHCCCS ID, and

iii. Member DOB.

d. Member name and either AHCCCS ID or Member

DOB on the subsequent pages of the Medical Record.

e. The following past medical history:

i. Disabilities,

ii. Any previous illness or injuries,

iii. Smoking,

iv. Alcohol/substance use,

v. Allergies,

vi. Adverse reactions to medications,

vii. Hospitalizations,

viii. Surgeries,

ix. Emergent/urgent care received, and

x. Immunization records: required for children, recommended for adult Members if available.

2. The AdSS shall require Providers to do the following regarding Medical Records:

a. Hard copy Medical Records be written legibly in blue or black ink, signed, and dated by the rendering Provider for each entry.

b. Electronic format Medical Records contain the name of

the Provider who made the entry and the date for each entry.

c. If revisions to information are made, a system is in place to track when and by whom the revisions are made.

d. That a back-up system is maintained that tracks initial and revised information.

e. That if a Medical Record is physically altered:

i. The stricken information be identified as a correction and initialed by the rendering Provider altering the record, along with the date when the change was made;

ii. That correction fluid or tape is not used;

iii. If Medical Records are kept in an electronic file, the Provider establish a method for indicating the author; date; and time of added and revised information; and

iv. Ensure that information is not inadvertently altered.

f. That Providers in multi-Provider offices have the treating Provider sign their treatment notes after each appointment

and procedure and occurs r as close to the actual entry of treatment notes as possible, based on either professional standards of care or requirements specified within A.A.C. R9-10.

g. That evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances is documented in the Medical Record.

3. The AdSS shall require the Provider to document the following coordination of care activities when they occur:

a. Referrals to other Providers;

b. Transmission of the diagnostic, treatment and disposition information related to a specific Member to the requesting Provider, as appropriate to promote continuity of care and quality management of the Member's health care;

c. Reports from referrals, consultations, and specialists for behavioral and physical health, as applicable;

d. Emergency and urgent care reports;

e. Hospital discharge summaries;

f. Transfer of care to other Providers;

g. Any notification when a Member's health status changes or new medications are prescribed;

h. Legal documentation that includes:

i. Documentation related to requests for release of information and subsequent releases,

ii. Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker, and

iii. Copies of any Advance Directives or Mental Health Care Power of Attorney as follows:

a) Documentation that the adult Member was provided the information on Advance Directives and whether an Advance Directive was executed, as specified in AdSS Medical Policy 640;

b) Documentation of general and informed consent to treatment, as specified in AdSS

Medical Policy 320-Q; and

c) Authorization to disclose information.

4. The AdSS shall refer to AMPM Policy 710 for Medical Record information regarding Members who receive Medicaid direct services through their school system.

C. PRIMARY CARE PROVIDERS PHYSICAL HEALTH MEDICAL RECORD REQUIREMENTS

1. The AdSS shall require any Provider delivering primary care services to a Member and acting as their Primary Care Provider (PCP) to maintain a comprehensive record that incorporates the following components:

   a. Initial history and comprehensive physical examination findings for the Member that includes family medical history, social history and preventive laboratory screenings.

   b. For Members under age 21, the initial history of prenatal care and birth history of the Member's mother while pregnant with the Member, if known;

c. Documentation of any requests for forwarding of behavioral health and other Medical Record information;

d. Behavioral health history and information received from a TRBHA or other Provider involved with the Member's behavioral health care;

e. If the Provider has not yet seen the assigned Member, Medical information detailed in this subsection may be kept in an appropriately labeled file until associated with the Member's Medical Record as soon as the Medical Record is established;

f. Documentation, initialed by the Provider, to signify review of the following diagnostic information:

i. Laboratory tests and screenings,

ii. Radiology reports,

iii. Physical examination notes,

iv. Medications,

v. Last Provider visit,

vi. Recent hospitalizations, and

vii. Other pertinent data to the Member's health conditions;

g. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools;

h. Current and complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Tracking forms or an equivalent including, at minimum all data elements on the EPSDT Tracking Form for:

i. All Members age 0 through 20 years;

ii. Developmental screening tools for children ages nine, 18, and 24 months;

iii. Dental history if available, and current dental needs and services;

iv. Current problem list;

v. Current medications list;

vi. Documentation to reflect review of the CSPMP database prior to prescribing a controlled

substance or another medication that is known to adversely interact with controlled substances; and

vii. Evidence that obstetric Providers complete a standardized, evidence- based risk assessment tool for obstetric Members as detailed in AdSS Medical Policy 410.

D. BEHAVIORAL HEALTH MEDICAL RECORD REQUIREMENTS

The AdSS shall require the following elements to be included in all behavioral health Medical Records:

a. Initial behavioral health evaluation containing the following:

i. Documentation of the Member's choice for receipt of the Member Handbook, either hard copy or electronic format;

ii. Receipt of Notice of Privacy Practice;

iii. Contact information for the Member's PCP; and

iv. Financial documentation for Non-Title XIX/XXI Members receiving behavioral health services, as outlined in AMPM Policy 650 occurring at the

following:

a) At the initial evaluation appointment,
b) When the Member has had a significant change in their income, and
c) At least annually.

b. Behavioral health assessment documentation consisting of:

i. Documentation of all information collected in the behavioral health assessment and any applicable addenda and required demographic information;

ii. Diagnostic information including psychiatric, psychological, and physical health evaluations;

iii. Evaluation of the need for reporting as required under A.R.S. §13- 3620;

iv. Copies of documentation related to the need for special assistance, if applicable, as detailed inAdSS Medical Policy 320-R; and

v. An English version of the behavioral health assessment, Service Plan, and Treatment Plan, when applicable, if the documents are completed in

any language other than English.

c. Service Plan documentation that contains:

i. The Member's Service Plan or Treatment Plan, as applicable;

ii. CFT documentation, based on Member's age (0 to 18 or up to 21 should Member choose to continue with Child & Family team after turning 18);

iii. ARTs documentation for adults 18 and older; and

iv. Progress Reports, Service Plans, or Treatment Plans from all other Providers, as applicable.

d. Progress note documentation that includes:

i. Documentation of the type of services provided;

ii. The diagnosis, containing an indicator that identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis;

iii. The progress note diagnosis code, if applicable;

iv. The date the service was delivered;

v. The date and time the progress note was signed;

vi. The signature of the staff that provided the service, including the staff Member's credentials;

v. Duration of the service (time increments);

vi. A description of what occurred during the provision of the service related to the Member's Service Plan;

vii. Documentation of the need for the involvement of multiple Providers, including the name and roles of each Provider involved in the delivery of services, in the event that more than one Provider simultaneously provides the same service to a Member; and

viii. The Member's response to service.

e. The Notice of Extension (NOE) and any other

documentation used for the processing of any applicable appeal; that was sent to the Member and their legal guardian or authorized representative.

E. REQUIREMENTS FOR POLICIES AND PROCEDURES FOR ENSURING MEDICAL RECORD CONTENT

1. The AdSS shall implement and maintain policies and procedures to ensure that Providers have information required to monitor effective and continuous physical and behavioral health care for Members through accurate Medical Record documentation regardless of whether records are hard copy or electronic via:

   a. Onsite or electronic quality review;

   b. Initial and on-going monitoring of Medical Records;

   c. Review of health status, changes in health status, health care needs, and services provided;

   d. Review of coordination of care activities;

   e. Maintenance of a legible Medical Record for each Member who has been seen for physical and behavioral health

appointments and procedures;

f. The Medical Record shall also contain clinical records from other Providers who also provide care or services to the Member; and

g. Medical Record requirements for hard copy and electronic Medical Records.

2. The AdSS shall have policies and procedures in place that meet federal and state requirements including those related to security and privacy in accordance with 45 CFR 160, 162, and 164, 45 CFR 43142 CFR 431.300 et seq., and Medicaid Information Technology Architecture (MITA) for the use of electronic Medical Records and for HIE via the state's HIO and digital (electronic) signatures that contain the following elements:

a. Signer authentication;

b. Message authentication;

c. Affirmative act (i.e. an approval function such as

a signature which establishes the sense of having legally consummated a transaction);

d. Efficiency; and

e. Medical Record review.

3. The AdSS shall implement policies and procedures that:

a. Support Members' rights to request and receive a copy of their Medical Record at no cost and to request that the Medical Record be amended or corrected;

b. Ensure information from or copies of Medical Records are released only to the Member or their Health Care Decision Maker.

c. Ensure that unauthorized individuals cannot gain access to, or alter Member Medical Records; and

d. Ensure Medical Records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of Member medical information.

4. The AdSS shall have written policies and procedures

addressing appropriate and confidential exchange of Member information among Providers.

5. The AdSS shall conduct reviews of Provider's policies and procedures to verify that they contain the following requirements:

   a. A Provider making a referral are to transmit necessary information to the Provider receiving the referral,

   b. A Provider furnishing a referral service reports appropriate information to the referring Provider,

   c. Providers request information from other treating Providers as necessary to provide appropriate and timely care, and

   d. Information about services provided to a Member by a non-network Provider is transmitted to the Member's Provider.

   e. Medical Records are transferred to the new Provider within 10 business days from receipt of the request for transfer of Medical Records to ensure continuity of care

when a Member chooses a new Provider; and

f. Member information is shared when a Member enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

F. METHODOLOGY FOR CONDUCTING MEDICAL RECORD REVIEW PROCESS

1. The AdSS shall require that the Medical Record audit process includes the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit.

2. The AdSS may, if they choose, utilize the AzAHP to conduct Medical Record review and other Provider documentation review processes.

3. The AdSS shall utilize the following methodology when conducting a Medical Record review of Providers:

   a. Medical Record reviews using a standardized tool that has been reviewed by the Division.

   b. Review the following physical health records:

i. EPSDT,

ii. Family planning, and

iii. Maternity components not otherwise monitored for Provider compliance by the AdSS.

c. Review the following elements of behavioral health Medical Records:

i. Assessments; and

ii. Service and treatment planning.

iii. Ensure individual elements delineate which requirements pertain to:

a) The unique needs of individual lines of business,

b) The following special populations:

1) General Mental Health/Substance Use (GMH/SU),

2) Serious Mental Illness (SMI),

3) Special Health Care Needs (SHCN),

4) Comprehensive Health Plan (CHP), or

5) Individuals receiving services under DDD.

d. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. At a minimum of every three years for physical health charts; and

ii. Yearly for behavioral health charts.

e. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. Conduct medical records reviews at a minimum of every three years for physical health charts (AMRR); and

ii. Yearly for behavioral health charts

f. Use of AdSS staff with the appropriate licensure and experience necessary for completion of either clinical charts for behavioral health services or physical health services to conduct the Medical Record reviews.

   i. The AdSS shall utilize licensed behavioral health professionals (BHPs) or behavioral health technicians (BHTs) with a minimum of three years' experience as a BHT and under the supervision of a BHP for behavioral health clinical chart audits; and

   ii. The AdSS shall utilize a registered nurse (RN) or a licensed practical nurse (LPN) with current licensure under the Arizona State Board of Nursing for AMRR audits.

g. The AdSS shall make available the results of the Medical Record review to all contractors who utilize a consultant such as AzAHP, or in instances when multiple contractors share the same Provider for this process.

h. The AdSS shall share the deficiencies identified during a Medical Record review with all health plans contracted with the Provider.

i. If quality of care issues are identified during the Medical Record review process, the AdSS shall notify all contractors which contract with the identified Provide, within 24 hours of identification of the quality of care issue with specifics concerning the quality of care issue.

j. If the AdSS requests approval from the Division to discontinue conducting the Medical Record reviews, the AdSS shall do the following prior to making the request:

   i. Conduct a comprehensive review the use of the Medical Record review process and how the process is used to document compliance with the Division and AHCCCS requirements;

   ii. Document what processes will be used in place of the Medical Record review process to ensure

compliance with the Division and AHCCCS requirements; and

iii. Submit the process the AdSS will utilize to ensure Provider compliance with the Division and AHCCCS Medical Record requirements to the AHCCCS/Quality Management/Clinical Quality Management Administrator prior to discontinuing the Medical Record review process.

4. The AdSS shall include all PCPs that serve Members less than 21 years of age and obstetricians/gynecologists in the AMRR process.

5. The AdSS shall review eight charts per practitioner and include the requirements specified in contract as a part of the AMRR.

6. The AdSS shall include in the behavioral health Medical Record review process:

   a. Behavioral Health Outpatient Clinics, and

   b. Integrated Health Homes and Federally Qualified Healthcare Centers (FQHCs) if they provide both

behavioral health and physical health care.

7. The AdSS shall follow the medical review process for behavioral health records as specified in contract.

8. For changes in methodology or sampling, the AdSS shall submit to the Division and AHCCCS in advance for approval as specified in the contract.

G. MULTI-SPECIALTY INTEGRATED CLINIC

1. The AdSS shall implement written policies and procedures to require that MSICs have an integrated electronic Medical Record for each Member that is served through the MSIC.

2. The AdSS shall require the MSIC's integrated electronic Medical Record:

   a. Be available, electronically through the HIE, for the multi-specialty treatment team and community Providers;

   b. Contains all information necessary to facilitate the coordination and quality of care delivered by multiple Providers in multiple locations at varying times; and

c. For care coordination purposes, is shared with other care Providers, such as the multi-specialty interdisciplinary team.

H. COMMUNITY SERVICE AGENCY, THERAPEUTIC FOSTER CARE PROVIDERS, AND HABILITATION PROVIDER REQUIREMENTS

1. For Community Service Agencies (CSAs), Therapeutic Foster Care (TFC) Providers, and Habilitation Providers, the AdSS shall require that the Medical Records conform to the following standards:

   a. Each record entry be:

      i. Dated and signed with credentials noted;

      ii. Legible text, written in blue or black ink, or typewritten; and

      iii. Factual and correct.

2. If Medical Records are kept in more than one location, the AdSS shall require the agency orProvider to:

a. Maintain documentation specifying the location of the Medical Records;

b. Maintain a Medical Record of the services delivered to each Member; and

c. Meet the following requirement for each Member's Medical Record:

i. The service provided and the time increment;

ii. Signature and the date the service was provided;

iii. The name, title, and credentials of the professional providing the service;

iv. The Member's Date of Birth and AHCCCS identification number;

v. Documentation that services are reflected in the Member's Service Plan or Treatment Plan, as applicable;

vi. Maintain a copy of theMember's Service Plan or Treatment Plan, as applicable, in the Member's

Medical Record; and

vii. Maintain a monthly summary of service documentation progress toward treatment goals.

d. The AdSS shall require Providers to transmit a summary of the monthly summary of service to the Member's clinical team for inclusion in the comprehensive Medical Record.

I. DESIGNATED RECORD SET

1. The AdSS shall treat the DRS as the property of the Provider who generates the DRS.

2. The AdSS shall require that Providers allow Members to:

a. Review, request, and annually receive a copy, free of charge, of those portions of the DRS generated by the Provider;

b. Request that specific Provider information is amended or corrected; and

c. Not review, request, amend, correct, or receive a copy

of the portions of the DRS that are prohibited from view under Health Insurance Portability and Accountability Act (HIPAA).

3. The AdSS shall provide sufficient copies of records necessary for administrative purposes to the Division or AHCCCS free of charge for purposes relating to treatment, payment, or health care operations.

4. The AdSS shall not require the PCP to obtain written approval from the Member when:

   a. Transmitting Medical Records to a Provider when services are rendered to the Member through referral to an AdSS subcontracted Provider,

   b. Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services, or

   c. Sharing Medical Records with the Member's AdSS.

5. The AdSS shall require AHCCCS-registered Providers to forward

Medical Records or copies of Medical Record information related to a Member to the Member's PCP within 10 business days from receipt of a request from the Member or the Member's PCP.

6. The AdSS shall provide access to the Division or AHCCCS to all Medical Records, whether electronic or hard copy, within 20 business days of receipt of a request.

7. The AdSS shall release information related to fraud, waste, or abuse against the AHCCCS program to authorized officials in compliance with Federal and State statutes and rules.

8. The AdSS shall demonstrate evidence of professional and community standards and accepted and recognized evidence-based practice guidelines as specified ine Division Medical Manual Chapter 500.

9. The AdSS shall require the Provider to have an implemented process to assess and improve the content, legibility, organization, and completeness of Medical Records when concerns are identified with the Providers Medical Records.

10. The AdSS shall require documentation in the Medical Record

showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

J. LEGAL REQUIREMENTS FOR RECORD MAINTENANCE

1. Consistent with 9 A.A.C. 22, Article 5, the AdSS, Providers, and non-contracted entities providing services to Members shall safeguard the privacy of Medical Records and information about Members who request or receive services from AHCCCS or its contractors.

2. The AdSS shall require that the content of any Medical Record be disclosed in accordance with the prior written consent of the Member with respect to whom such record is maintained as allowed under regulations prescribed pursuant to 42 U.S.C. §290 dd-2, 42 CFR Part 2, 2.1 – 2.67.

3. The AdSS shall release original and copies of Medical Records only in accordance with Federal or State laws, and AHCCCS and Division policy and contracts.

4. The AdSS shall comply with HIPAA requirements and 42 CFR 431.300 et seq.

5. The AdSS shall align the Medical Records retention processes with AHCCCS and Division contract and TRBHA Intergovernmental Agreement (IGA) requirements.

6. The AdSS shall require that maintenance and access to Medical Records survive the termination of a Provider's contract regardless of the cause of termination.

7. The AdSS and Providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.

8. The AdSS shall encourage non-contracted entities that provide services to Members to cooperate and participate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.

K. UNITED STATES CORE DATA FOR INTEROPERABILITY

The AdSS shall incorporate United States Core Data for

Interoperability (USCDI) Data Elements as part of the DRS to facilitate the electronic exchange of an individual's Medical Record data as requested by the individual.

Signature of Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:17 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

The requirements listed below are additional requirements under USCDI. The Division and AHCCCS strongly recommend these enhanced data elements be added to the existing Physical and Behavioral Health Medical Record requirements specified in this policy. Per the ONCs, disclosure of these additional data elements is subject to the confidentiality requirements of applicable state laws.

1. Medical Record requirements are applicable to both hard copy and electronic Medical Records. Medical Records may be documented on hard copy or in an electronic format. The AdSS' Provider shall include the following in their records:

2. Documentation of identifying demographics, including:
    a. Any previous names by which the Member is known,
    b. Previous address,
    c. Telephone number with cell or home designation, and both if applicable,
    d. Email address,
    e. Birth sex,
    f. Race,
    g. Ethnicity, and
    h. Preferred language.
3. For records relating to provision of behavioral health services, documentation including, but not limited to:
    a. Behavioral health history,
    b. Applicable assessments,
    c. Service plans and/or treatment plans,
    d. Crisis and/or safety plan,
    e. Medication information if related to behavioral health diagnosis,
    f. Medication informed consents, if applicable
    g. Progress notes, and

h. General and/or informed consent.

4. Documentation, initialed by the Provider, to signify review of diagnostic information including vital signs data at each visit, to include:

   a. Body temperature,

   b. Diastolic and Systolic blood pressure,

   c. Body height and weight,

   d. BMI Percentile (two -20 years),

   e. Weight-for-length percentile (birth-36 months),

   f. Head occipital-frontal circumference percentile (birth-36 months),

   g. Heart rate and respiratory rate,

   h. Pulse oximetry,

   i. Inhaled oxygen concentration, and

   j. Unique device identifier(s) for implantable device(s), as applicable.

5. For Inpatient Settings – Clinical Note Requirements:

   a. Consultation notes,

   b. Discharge and summary notes,

   c. History and physical,

d. Imaging narrative,

e. Laboratory report narrative,

f. Pathology report narrative,

g. Procedure notes, and

h. Progress notes.

950 CREDENTIALING AND RECREDENTIALING PROCESSES

REVISION DATE: 9/6/23, 5/18/22
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-114, A.A.C. R9-10-115; 42 CFR 8.11, CFR 438, 42 CFR 455.1(a)(1), 42 CFR 455.14, 42 CFR 455.17, 42 CFR 455 Subpart B, 42 CFR 457.1201(f), 42 CFR 457.1208, 42 CFR 457.1230(a), 42 CFR 457.1233(a), IRC of 1986 7701(A)(41).

PURPOSE

This policy establishes the requirements for initial Credentialing, temporary/provisional Credentialing, and recredentialing of individual and Organizational Providers conducted by the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a Provider's practice, including contract termination, suspension, limitations, continuing education requirements, monitoring, supervision.
2. "Completed Application" means when all accurate information and documentation is available to make an informed decision about the Provider.

3. "Credentialing" means a process in which written evidence of qualifications are obtained in order for practitioners to participate under contract with a specific health plan.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Network Provider" means, for the purpose of this policy, an individual or entity which has signed a Provider agreement as specified in A.R.S. § 36-2904 and that has a subcontract, or is authorized through a subcontract, to provide services pursuant to A.R.S. § 36-2901 et seq. for Members served by the AdSS health plan.
6. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
7. "Primary Source Verification" means the process by which an individual Provider's reported credentials and qualifications are confirmed with the original source or an approved agent of that source.
8. "Provider" means any individual or entity that contracts with the AdSS for the provision of covered services, or ordering or referring for those services to Division Members enrolled in an AdSS' health plan, or any

subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The AdSS shall have a written process and a system in place for Credentialing and recredentialing Providers in its Provider Network.
2. The AdSS shall document Credentialing and recredentialing for all Providers delivering care and services to Division Members enrolled in the AdSS' health plan.
3. The AdSS shall utilize the Arizona Association of Health Plans' contracted Credential Verification Organization as part of the Credentialing and recredentialing process.
4. The AdSS shall ensure the Credentialing and recredentialing processes:
   a. Do not base Credentialing decisions on an applicant's race, gender, age, sexual orientation, or patient type in which the Provider specializes.
   b. Do not discriminate against Providers who serve high-risk

populations or who specialize in the treatment of costly conditions.

c. Comply with federal requirements that prohibit employment or contracts with Providers excluded from participation under either Medicare or Medicaid, or that employ individuals or entities that are excluded from participation.

5. If the AdSS delegate any Credentialing and recredentialing responsibilities to another entity, the AdSS shall retain the right to approve, suspend, or terminate any Provider selected by that entity.

6. The AdSS shall establish a Credentialing Committee to review and make decisions on Provider Credentialing.

7. The AdSS shall have written policies and procedures that:

a. Reflect the direct responsibility of the AdSS' local Chief Medical Officer or designated Medical Director, or in the absence of the Chief Medical Officer or designated Medical Director, another local designated physician to:

i. Act as the Chair of the Credentialing Committee;

ii. Implement the decisions made by the Credentialing Committee; and

iii. Oversee the Credentialing process;

b. Indicate the use of participating Arizona Medicaid Network Providers in making Credentialing decisions;

c. Describe the methodology to be used by the AdSS' staff and the local Chief Medical Officer or designated Medical Director to provide documentation that each Credentialing/ Recredentialing file was completed and reviewed prior to the presentation to the Credentialing Committee for evaluation; and

d. Notify Providers of their right to:

i. Review information obtained to evaluate the Credentialing application, attestation, or curriculum vitae;

ii. Correct erroneous information; and

iii. Receive the status of their Credentialing application upon request.

8. The AdSS shall maintain an individual electronic or hard copy Credentialing/Recredentialing file for each applying Provider and ensure each file contains:
    a. The initial Credentialing and all subsequent recredentialing applications and attestation by the Provider of the correctness and completeness of the application as demonstrated by the signature on the application;
    b. Information gained through Credentialing and recredentialing queries;
    c. Any other pertinent information used in determining whether the Provider met the AdSS' Credentialing and recredentialing standards; and
    d. Specific to recredentialing, utilization data, quality of care concerns, grievances, performance measure rates, value-based purchasing results, and level of Member satisfaction.
9. The AdSS shall enter the credentialed Providers into the AdSS' claims payment system within 30 calendar days of the Credentialing approval with an effective date no later than the

date the Provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

10. The AdSS shall reimburse Providers who submit claims for covered services provided to Members during the Credentialing process on or after the date of the Completed Application as defined in this Policy. If the Provider is subsequently not approved through the Credentialing Committee, the AdSS shall recoup the funding.

11. The AdSS shall have an established process to notify Providers of the Credentialing decisions within 10 calendar days of Credentialing Committee decisions.

B. TEMPORARY/PROVISIONAL CREDENTIALING

1. The AdSS shall have policies and procedures to address granting of temporary/provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care prior to completion of the entire Credentialing process.

2. The AdSS shall credential the following Providers using the temporary/provisional Credentialing process, even if the Provider

does not specifically request their application be processed as temporary/provisional:

a. Providers in a Federally Qualified Health Center (FQHC);

b. Providers in a FQHC Look-Alike organization;

c. Rural Health Clinic (RHC);

d. Hospital employed physicians (when appropriate);

e. Providers needed in medically underserved areas;

f. Providers joining an existing, contracted oral health Provider group;

g. Covering or substitute Providers providing services to Members during a contracted Provider's absence from the practice;

h. Providers eligible under the Substance Abuse and Mental Health Services Administration Certified Opioid Treatment Programs as specified in 42 CFR 8.11; and

i. Providers as directed by AHCCCS during federal or state-declared emergencies where delivery systems are or have the potential to be disrupted.

3. The AdSS local Medical Director shall review the Credentialing information obtained and determine whether to grant temporary/provisional Credentialing.
4. The AdSS shall render a decision regarding temporary/ provisional Credentialing within 14 calendar days from the date of request or identified need.
5. Upon approval of the temporary/provisional Credentialing, the AdSS shall enter the Provider information into the AdSS' claims system to allow payment to the Provider effective the date the temporary/provisional Credentialing is approved.
6. For consideration of temporary/provisional Credentialing, at a minimum, the AdSS shall ensure the Provider has a Completed Application, signed and dated, that attests to the following elements:
    a. Reasons for any inability to perform the essential functions of the position with or without accommodation;
    b. Lack of present illegal drug use;
    c. History of loss of license or felony convictions;

d. History of loss or limitation of privileges or disciplinary action;

e. Current malpractice insurance coverage;

f. Attestation by the Provider of the correctness and completeness of the application;

g. Work history for the past five years or total work history if less than five years; and

h. Current Drug Enforcement Agency or Controlled Drug System certificate if a prescriber.

7. The AdSS shall conduct Primary Source Verification of the following:

a. Licensure or certification;

b. Board certification, if applicable, or the highest level of credential attained; and

c. National Practitioner Data Bank (NPDB) query with:

i. Minimum five-year history of professional liability claims resulting in a judgment or settlement;

ii. Disciplinary status with regulatory board or agency;

iii. State sanctions or limitations of licenses; and

iv. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

8. If a covering or substitute Provider is used by a contracted Provider, and is approved through the temporary/provisional Credentialing process, the AdSS shall ensure that the claims system allows payments to the covering or substitute Provider effective the date the notification was received from the Provider of the need for a covering or substitute Provider.

9. The AdSS shall require covering or substitute Providers to meet the following requirements:

   a. Licensure: Providers and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing.

   b. Restriction of licensure: Providers shall notify the AdSS within two business days of the loss or restriction of a Drug Enforcement Agency permit or license, or any other action that limits or restricts the Provider's ability to practice or

provide services.

c. Professional Training: Providers and all employees rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to Members.

d. Professional Standards: Providers and employees rendering services to Members shall provide care and services which meet or exceed the standard of care and shall comply with all standards of care established by state or federal law.

e. Continuing education: Providers and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

f. Regulatory compliance: Providers shall meet the minimum requirements for participating in the Medicaid program as specified by the state.

10. Following approval of temporary/ provisional Credentialing, the AdSS shall complete the entire initial Credentialing process as specified in this policy.
11. The AdSS shall not keep Providers in a temporary/provisional Credentialing status for longer than 60 calendar days.

C. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The AdSS shall complete the individual Provider Credentialing for the following provider types:
    a. Medical Doctor;
    b. Doctor of Osteopathic Medicine;
    c. Doctor of Podiatric Medicine;
    d. Naturopathic Doctor and Naturopathic Medical Doctor;
    e. Nurse Practitioner;
    f. Physician Assistant;
    g. Certified Nurse Midwife acting as Primary Care Provider, including prenatal care and delivering Provider;
    h. Doctor of Dental Surgery and Doctor of Medical Dentistry;
    i. Affiliated Practice Dental Hygienist;
    j. Psychologist;

k. Optometrist;

l. Certified Registered Nurse Anesthetist;

m. Occupational Therapist;

n. Speech and Language Pathologist;

o. Physical Therapist; and

p. Independent behavioral health professionals who contract directly with the AdSS;

q. Board Certified Behavioral Analyst (BCBA);

r. Any non-contracted certified or licensed provider that is rendering services and sees 50 or more Members served by the AdSS per contract year; and

s. Any covering/substitute oral health providers that provide care and services to Members served by the AdSS in the absence of the contracted Provider.

2. The AdSS shall have a process for initial Credentialing of individual Providers that includes:

a. A written application to be completed by the Provider that attests to the following elements:

i. Reasons for any inability to perform the essential

functions of the position with or without accommodation;

ii. Lack of present illegal drug use;

iii. History of loss of license or felony convictions;

iv. History of loss or limitation of privileges or disciplinary action;

v. Current malpractice insurance coverage;

vi. Attestation by the Provider of the correctness and completeness of the application;

vii. Minimum five-year work history or total work history if less than five years; and

viii. Electronic Vendor Verification attestation form if applicable.

b. Drug Enforcement Administration or Chemical Database Service certification if a prescriber.

c. Verification from primary sources of:

i. Licensure or certification; and

ii. Board certification, if applicable, or highest level of credentials attained.

iii. For Credentialing of Independent Masters Level Behavioral Health Licensed Professionals, Primary Source Verification of:

a) Licensure by the Arizona Board of Behavioral Health Examiners (AZBBHE); and

b) A review of complaints received and disciplinary status through AZBBHE.

iv. For Credentialing of licensed BCBA, Primary Source Verification of:

a) Licensure by the Arizona Board of Psychologist Examiners; and

b) A review of complaints received and disciplinary status through the Arizona Board of Psychologist Examiners.

v. Documentation of graduation from an accredited school and completion of any required internships or residency programs, or other postgraduate training. A printout of license from the applicable Board's official website denoting that the license is active

with no restrictions is acceptable.

vi. National Practitioner Data Bank query including :

a) Minimum five-year history of professional liability claims resulting in a judgment or settlement;

b) Disciplinary status with regulatory board or agency;

c) State sanctions or limitations of licenses; and

d) Medicare/Medicaid sanctions, exclusions, and terminations for cause.

vii. Documentation that the following sites have been queried:

a) Health and Human Services Office of Inspector General List of Excluded Individuals/Entities, and

b) The System of Award Management formerly known as the Excluded Parties List System.

3. The AdSS shall ensure affiliated practice dental hygienists provide documentation of the affiliation agreement with an

AHCCCS registered dentist.

4. The AdSS may conduct an initial site visit as part of the Credentialing process.
5. For Locum Tenens, the AdSS shall verify the status of the physician with the Arizona Medicaid Board and national databases.
6. The AdSS shall ensure that Network Providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical and mental disabilities.
7. The AdSS shall ensure that network Providers deliver services in a culturally competent manner, including members with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.
8. The AdSS shall conduct timely verification of information as evidenced by approval or denial of a Provider within 60 days of receipt of a complete application.

D. RECREDENTIALING OF INDIVIDUAL PROVIDERS

The AdSS shall have recredentialing procedures that address the following requirements:

1. Recredentialing at least every three years.
2. Primary source verification current within 180 days of the recredentialing decision.
3. An update of information obtained during the initial Credentialing process as specified within this policy.
4. Verification of continuing education requirements being met.
5. A process for monitoring health care Provider specific information.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contracting with an Organizational Provider, the AdSS shall ensure that the Organizational Provider has established policies and procedures that meet Division and AHCCCS requirements, including policies and procedures for Credentialing if those functions are delegated to the Organizational Provider.

2. Prior to Credentialing and contracting with an Organizational Provider, the AdSS shall:

   a. Confirm the Organizational Provider has met all the state and federal licensing and regulatory requirements. A copy of the license or letter from the regulatory agency will meet this requirement.

   b. Confirm that the Organizational Provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS). A copy of the accreditation report or letter from the accrediting body will meet this requirement.

   c. Conduct an onsite quality assessment if the Organizational Provider is not accredited.

   d. Develop a process and utilize assessment criteria for each type of unaccredited Organizational Provider that confirms that the Organizational Provider has the following:

      i. A process for ensuring that the Organizational Provider credentials its Providers for all employed and contracted Providers as specified in this policy;

ii. Liability insurance;

iii. Business license; and

iv. CMS certification or state licensure review may be substituted for the required onsite quality assessment if the review was within the past three years prior to the Credentialing date.

a) If a review was conducted within the past three years, obtain the documentation from CMS or the state licensing agency and verify that the review was conducted and that the Organizational Provider meets the AdSS' standards.

b) A letter from CMS that states the Organizational Provider was reviewed and passed inspection is sufficient documentation when the AdSS have documented that they have reviewed and approved the CMS criteria and they meet the AdSS' standards.

e. Confirm maintenance schedules for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children.

f. Review and approve the Organizational Provider through the AdSS's Credentialing Committee.

3. The AdSS shall ensure Community Service Agencies are credentialed according to AHCCCS Medical Policy 965.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The AdSS shall recredential Organizational Providers at least every three years using the following components:

a. Confirmation that the Organizational Provider remains in good standing with state and federal bodies by validating that the Organizational Provider:

i. Is licensed to operate in the state and is in compliance with any other state or federal requirements, as applicable; and

ii. Is reviewed and approved by an appropriate accrediting body.

b. Review of the following:

i. The most current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings, documented by review date, and if applicable, the online Hospital Compare Az Care Check.

ii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications.

iii. Supervision of staff and required documentation of direct supervision or clinical oversight, including a review of a valid sample of clinical charts.

iv. Most recent audit results of the Organizational Provider.

v. Confirmation that the service delivery address is verified as correct.

vi. Review of staff to verify credentials and that staff meet the Credentialing requirements.

c. Evaluation of Organizational Provider specific information related to:

i Member concerns and grievances;

ii. Utilization management information;

iii. Performance improvement and monitoring;

iv. Quality of care issues;

v. Onsite quality assessment; and

vi. Review of any Adverse Actions.

d. Review and approval by the AdSS' Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

2. The AdSS shall review and monitor other types of Organizational Providers in accordance with the AdSS' contract.

3. If an Organizational Provider is not accredited or surveyed and licensed by the state, the AdSS shall conduct an onsite review.

G. NOTIFICATION REQUIREMENTS

1. The AdSS shall have written procedures for reporting to AHCCCS, Division of Health Care Management (DHCM), Quality

Management (QM), the Division's Quality Management Unit (QMU), the Provider's regulatory board or agency, ADHS Licensure Division, the Office of the Attorney General, and any other appropriate agencies.

2. The AdSS shall report any issues or quality deficiencies that result in a Provider's suspension or termination from the AdSS' network to AHCCCS/DHCM/QM and the Division QMU within one business day of the determination to take the Adverse Action.
3. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS shall notify the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.
4. The AdSS shall have an implemented process to report Providers to licensing and other regulatory entities for allegations of inappropriate or misuse of prescribing practices.
5. The AdSS shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHCM/QM and the Division QMU within one business day of determination to take the Adverse Action and include the

reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.

6. The AdSS shall have an appeal process for Providers when restrictions are placed on the Provider's contract and a method to inform the Provider of the appeal process.
7. The AdSS shall have written procedures for reporting to AHCCCS/DHCM/QM and the Division QMU any final Adverse Action, taken against a Provider, supplier, vendor, or practitioner for any quality-related reason.
8. The AdSS shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.
9. The Division shall consider the following to be a final Adverse Action:
    a. Civil judgments in federal or state court related to the delivery of a health care item or service;
    b. Federal or state criminal convictions related to the delivery of a health care item or service;

c. Actions by federal or state agencies responsible for the licensing and certification of health care Providers, suppliers, and licensed health care practitioners, including:

i. Formal or official actions, such as restriction, revocation, suspension of license and length of suspension, reprimand, censure or probation;

ii. Any other loss of license or the right to apply for or renew a license of the Provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability or otherwise; or

iii Any other negative action or finding by such federal or state agency that is publicly available information.

iv. Exclusion from participation in federal or state health care programs as defined in 42 CFR 455 Subpart B; and

v. Any other adjudicated actions or decisions that the Secretary of the U.S. Department of Health and Human Services shall establish by regulation.

vi. Any adverse Credentialing decision made on the basis of quality-related issues or concerns.

vii. Any Adverse Action from a quality or peer review process that results in denial of a Provider to participate in the AdSS network, Provider termination, Provider suspension, or an action that limits or restricts a Provider.

10. The AdSS shall submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) within 30 calendar days from the date the final Adverse Action was taken, or the date when the AdSS became aware of the final Adverse Action, or by the close of the AdSS' next monthly reporting cycle, whichever is later.

11. The AdSS shall send a notice of final Adverse Action to AHCCCS/DHCM/QM and the Division QMU within one business day and provide the following information:

    a. The name and Tax Identification Number as defined in section 7701(A)(41) of the Internal Revenue Code of 1986 (1121).

b. The name (if known) of any heath care entity with which the health care Provider, supplier, or practitioner is affiliated or associated.

c. The nature of the final Adverse Action and whether such action is on appeal.

d. A description of the acts or omissions and injuries upon which the final Adverse Action was based.

e. The date the final Adverse Action was taken, its effective date, and duration of the action.

f. Corrections of information already reported about any final Adverse Action taken against a Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

   i. System of Award Management, formerly known as the Excluded Parties List System;

   ii. The Social Security Administration's Death Master File;

   iii. The National Plan and Provider Enumeration System;

   iv. List of Excluded Individuals/Entities; and

v. Any other databases directed by AHCCCS, the Division, or CMS.

12. In accordance with A.R.S. §36-2918.01 §36-2905.04, §36-2932, the AdSS shall ensure that the AHCCCS OIG is immediately notified regarding any allegation of fraud, waste, or abuse of the Medicaid Program, in accordance with AdSS Operations Policy 103 and as specified in the AdSS' contract, including allegations of fraud, waste, or abuse that were resolved internally but involved Medicaid funds.
13. The AdSS shall report to AHCCCS and the Division QMU any Credentialing denials issued by the Credential Verification Organization that are the result of licensure issues, quality of care concerns, excluded Providers, and which are due to alleged fraud, waste, or abuse.
14. The AdSS shall provide notification regarding Credentialing denials and approvals to the applicable Providers with 10 calendar days of Credentialing Committee decisions.

H. CREDENTIALING TIMELINESS AND REPORTING

1. The AdSS shall process Credentialing applications in a timely manner as shown in the below table.
2. To assess the timeliness of Credentialing, the AdSS shall divide the number of complete applications approved or denied timely during the time period, per category, by the number of complete applications that were received during the time period, per category, as specified in AMPM 950 Attachment A.
3. The AdSS shall submit the Credentialing Report as specified in the AdSS' contract using AMPM 950 Attachment A, including specifying any areas of non-compliance and corrective actions taken during the reporting quarter in the comments section of the report.
4. The AdSS shall adhere to the timeline requirements listed below by category:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Temporary/Provisional Credentialing	14 Days	100%
Initial Credentialing of Individual and Organizational Providers	60 Days	100%
Recredentialing of Individual and Organizational Providers	Every three years	100%
Load Times (Time between Credentialing Committee approval and loading into Claims System)	30 Days	95%

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 16:40 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

A. THERAPEUTIC FOSTER CARE PROVIDERS

1. Therapeutic Foster Care (TFC) Family Providers are licensed through the Department of Child Safety (DCS) and do not require Credentialing by the AdSS.
2. TFC Family Providers require credentialing with the Contractor.
3. For TFC Providers for children, submission of a Foster Home License, as specified in A.A.C. 21, Article 1 through 4, will be

accepted as meeting the requirements for Credentialing as an AHCCCS Provider.

B. MEDICAL AND DENTAL STUDENTS

1. AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist.
2. In limited circumstances when specific criteria are met, medical residents may provide low level evaluation and management services to members in designated settings without the presence of the teaching physician.
3. The teaching physician or teaching dentist must be an AHCCCS registered provider.

C. CONTINUING EDUCATION UNITS

TYPE	DESCRIPTION	LIMIT	CEU
1	College or university coursework	None – all CE can come from this type	1 hour of instruction = 1 CEU
2	CE issued by approved continuing education (ACE) Providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU

3	Instruction Type 1 or 2	50% can come from this type*	1 hour of instruction = 1 CEU
4	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
5	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CEUs, except for supervision
6	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

*A maximum of 75 percent of the total required CE may come from categories 3, 4, 5 and 7. At least 25 percent shall come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.

960 QUALITY OF CARE CONCERNS

REVISION DATE: 8/16/23, 6/29/22

EFFECTIVE DATE: October 1, 2019

REFERENCES: Administrative Services Subcontractor (AdSS) Medical Policies 910, 961, 320-U; AdSS Operations Policies 444, 446; 9 A.A.C. 34, A.A.C. R9-19-314 (B)(13) and A.A.C. R9-19-315(E), R9-21-4, R9-21-101(B), R9-21-401 et seq., R9-34 A.R.S. §§8-412(A), 12-901 et seq, 13-3620 §36-664(H), §36-517.02, 36-664, 41-3801, 41-3804, 46-454, 42 CFR Part 2, 42 CFR 447.26, 42 CFR 431.300 et seq, 42 CFR 482.13(e)(1) A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281. 45 CFR 160.103, 20 U.S.C. 1232g

PURPOSE

This policy sets forth the requirements for the Division's Administrative Services Subcontractors' (AdSS) regarding the process for reviewing, reporting, evaluating, and resolving Quality of Care Concerns raised by Members, subcontracted service providers, stakeholders, or any other internal or external sources.

DEFINITIONS

1. “Adverse Action” means any type of restriction placed on a provider’s practice by the Division.

2. “Health Care Acquired Condition” means a hospital acquired condition which occurs in any inpatient hospital setting and is not present on admission.

3. “High-Profile Case” means a case that attracts or is likely to attract attention from the public or media.

4. “Immediate Jeopardy” means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member.

5. “Incident, Accident, or Death” means an incident report entered into the Arizona Health Care Cost Containment System (AHCCCS) Quality Management (QM) Portal to document an occurrence that caused harm or may have caused harm to a Member or to report the death of a Member.

6. “Internal Referral” or “IRF” means a report entered into the AHCCCS QM Portal by an employee of a health plan to document an

occurrence that caused harm or may have caused harm to a member and or to report the death of a member.

7. "Investigation" means collection of facts and information for the purpose of describing and explaining an incident.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Other Provider Preventable Condition" means a condition occurring in an inpatient or outpatient health care setting which AHCCCS has limited to the following:

   a. Surgery on the wrong Member

   b. Wrong surgery on a Member

   c. Wrong site surgery

10. "Personally Identifiable Information" or "PII" means a person's name, address, date of birth, social security number, trial enrollment number, telephone or fax number, e-mail address, social media identifier, driver's license number, places of employment, school identification or military identification number or any other distinguishing characteristic that tends to identify a particular person as specified in A.R.S. 41-3804(K).

11. "Protected Health Information" or "PHI" means individually identifiable information as specified in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

    a. Created or received by a health care provider, health plan, employer, or health care clearinghouse.

    b. Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual.

12. "Provider-Preventable Condition" means a condition that meets the definition of a Health Care Acquired Condition or an Other Provider-Preventable Condition.

13. "Quality Management" or "QM" means the evaluation and assessment which can be assessed at a Member, Service Provider, or population level of Member care and services to ensure adherence to standards of care and appropriateness of services.

14. "Quality Management Unit /Performance Quality Improvement Team" or "QM/PI" means Division staff who:

a. Oversee the QOC Concern process;

b. Evaluate Administrative Services Subcontractors Quality Management/Performance Improvement Programs;

c. Monitor and evaluate adherence with required quality and performance improvement standards through standardized Performance Measures, Performance Improvement Projects, and Quality Improvement specific Corrective Action Plans; and

d. Provides technical assistance for performance improvement related matters.

15. "Quality of Care" or "QOC" means an expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provisions.

16. "Quality of Care Concern" or "QOC Concern" means an allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services that:

a. Caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric

condition, and

b. May ultimately cause the risk of harm to a Member.

17. "Responsible Person" means the same as defined in A.R.S. § 36-551.

18. "Restraint" means personal restraint, mechanical restraint or drug used as a restraint in a behavioral health inpatient setting and is the following as specified in 42 CFR 482.13(e)(1)

19. "Seclusion" means the involuntary confinement of a behavioral health recipient in a room or an area from which the person cannot leave.

20. "Seclusion of Individuals Determined to have a Serious Mental Illness" means the restriction of a behavioral health recipient to a room or area through the use of locked doors or any other device or method which precludes a person from freely exiting the room or area or which a person reasonably believes precludes his/her unrestricted exit as specified in A.A.C. R9-21-101(B).

a. In the case of an inpatient facility, confining a behavioral health recipient to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion.

b. In the case of a community residence, restricting a behavioral

health recipient to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion as specified in A.A.C. R9-21-101(B).

21. "Sentinel Event" means a Member safety event that results in death, permanent harm, or severe temporary harm.

22. "Severity Levels" means the level of acuity of a QOC and which is described in the following ranking:

Level 0: (Track and Trend Only) - No Quality issue Finding

Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.

Level 2: Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.

Level 3: Quality issue exists with significant adverse effects on the patient/recipient; is dangerous or life-threatening.

Level 4: Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others

POLICY

A. DOCUMENTATION OF QUALITY OF CARE AND SERVICE CONCERNS

The AdSS shall develop and implement written policies and procedures regarding the receipt, initial, and ongoing processing, and resolution of Quality of Care (QOC) or service concerns that addresses the following:

1. Documenting each issue raised, from whom it was received, and the projected time frame for resolution.

2. Determining whether one of the following processes will be used to resolve the issue:
   a. Quality Management (QM) process
   b. Grievance and appeals process
   c. Both the Grievance and QM processes concurrently
   d. Process for making initial determinations on coverage and payment issues
   e. Process for resolving disputed initial determinations.

3. Acknowledging receipt of the concern and providing an explanation of the process to be used to resolve the concern through written correspondence.

4. Informing the submitter of the process to be used to resolve the concern if the Quality Management Unit determines the concern not to be a Quality of Care Concern.

5. Assisting the Member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

6. Ensuring confidentiality of all Member information.

7. Informing the Member or provider of all applicable mechanisms for resolving the issue that are external to the AdSS processes.

8. Documenting all processes, including detailed steps used during the investigation and resolution stages, implemented to ensure complete resolution of each complaint, grievance, or appeal, including:

    a. Corrective action plan(s) or action(s) taken to resolve the concern;

    b. Documentation that training and education was completed, such as in-service attendance sheets and training objectives;

    c. New policies or procedures;

d. Follow-up with the Member that includes:

i. Assistance to ensure that the immediate health care needs are met;

ii. Resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns; and

iii. Referral to the AdSS' Corporate Compliance Unit, the Division, or AHCCCS Office of the Inspector General.

9. QOC Concerns that meet the reporting requirements specified in AdSS Policy 961, received outside of the AHCCCS QM Portal, the AdSS shall enter the QOC Concerns into the Portal as an Internal Referral (IRF) within one business day if the event is considered sentinel and two business days for all reportable incidents.

B. PROCESS OF EVALUATION AND RESOLUTION OF QOC AND SERVICE CONCERNS

1. The AdSS shall complete the QOC Concern investigation and documentation process within the AHCCCS QM Portal and include a summary of all applicable research, evaluation, intervention and resolution, details for each case.
2. The AdSS shall maintain a QOC investigation process that isa stand-alone process completed through the AdSS Quality Management Unit (QMU) and not combined with other agency meetings or processes.
3. Work units outside of the QMU:
    a. Shall not conduct QOC investigations.
    b. Shall provide subject matter expertise throughout the investigative process as requested by QMU.
4. The AdSS shall not delegate QOC investigation processes or onsite QOC visits.
5. Quality investigations may not be delegated or performed by the staff of the provider agency or facility where the identified health and safety concerns, Immediate Jeopardy, or Division-requested reviews have occurred.

6. The AdSS shall develop and implement policies and procedures that include at a minimum:

   a. Identification of QOC Concerns.

   b. Initial assessment of the severity of each QOC Concern.

   c. Prioritization of action(s) needed to resolve immediate care needs when appropriate.

   d. Review of trends related to Members, providers, including organizational providers, involved in the allegations, considering types and frequency of allegation(s), severity, and substantiation status, as well as systemic QOC Concerns, and referrals to Quality Management and Peer Review committees as appropriate.

   e. Research including:

      i. Review of the log of events.

      ii. Documentation of conversations including direct interviews of Members, staff, and witnesses to a reportable event.

iii. Medical records review.

iv. Mortality review.

f. Quantitative and qualitative analysis of the research, which may include root cause analysis.

c. The AdSS may request copies of a Member's death certificates by submitting a request to the Department of Health Services (ADHS) Vital Records and Statistics as specified in A.A.C. R9-19-314 B (13) and A.A.C. R9-19-315(E).

d. The AdSS' Quality Management staff shall conduct onsite visits when there are identified health and safety concerns, Immediate Jeopardy, or at the direction of AHCCCS or the Division.

e. The AdSS shall report onsite visits that are identified and conducted by the AdSS after 5:00 p.m. on weekdays, or that occur during weekends or on holidays to the Division QM Manager or supervisor by phone and followed up with an email to the Division the following business day.

10. Clinical Quality Management staff shall:

a. Be the lead responsible for the review and Investigation,

and

b. Participate in the onsite visits.

11. Subject matter experts outside of the AdSS QM Unit:

a. May participate in the onsite visit when necessary and appropriate; but

b. Shall not take the place of Quality Management staff during reviews.

12. The AdSS shall complete and submit to the Division the Health and Safety Update – Onsite Review Form as specified in the contract with the Division or each onsite review within 24 hours of the health and safety visit.

13. The AdSS shall, based on findings of the review:

a. Identify any immediate care or recovery needs and ensure incident resolution.

b. Develop work plans and corrective action plans to ensure placement setting or service site compliance with ADHS Licensure and Division requirements regarding policy,

training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation.

c. Conduct scheduled and unscheduled monitoring of placement setting or service sites in any of the following circumstances:

   i. In an Immediate Jeopardy status.

   ii. Multiple identified deficiencies that may affect health and safety of Members.

   iii. As determined by the AdSS QM Unit or as determined by the Division.

d. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.

e. Determine, implement, and document all appropriate interventions including an action plan to reduce or eliminate the likelihood of the concern recurring.

f. Monitor and document success of interventions.

g. Monitor placement setting or service sites upon completion

of the activities and interventions to ensure that compliance is sustained.

h. Implement new interventions and approaches when necessary.

i. Incorporate interventions into the AdSS's QM program plan if successful.

14. Ensure that investigation and resolution of Member and systemic concerns are processed timely based on the nature and severity of each case or as requested by the Division.

a. For high-profile cases, the AdSS shall communicate initial reports of immediate findings to the Division immediately but no later than 24 hours of the AdSS becoming aware of the concern and followed up by an initial finding report within seven business days.

b. For Member safety or placement concerns, the AdSS shall schedule a due date for the resolution of the case for 30 calendar days from the date of opening.

c. For other concerns, the AdSS shall schedule a due date for

resolution of the case for within 60 calendar days from the date of opening.

d. The AdSS shall track concerns that have aged to greater than 60 calendar days and must develop an action plan to address these cases.

e. The AdSS shall include a review of all paid claims within the last calendar year to identify the need to participate in systemic investigations when notified of provider concern to include single case agreements and providers using subcontracted providers.

15. The AdSS shall submit all requests for extensions of timelines associated with a QOC investigation to the Division for approval as soon as possible but no later than the assigned due date and must include at minimum:

a. The Member's current placement and condition.

b. The current status of the investigation.

c. The barrier to completing the investigation within the assigned time frame.

16. The AdSS shall update the case within the AHCCCS QM Portal to reflect changes during the investigation as additional details and allegations are discovered and added to the QOC.

17. The AdSS shall ensure the final Severity Level is assigned to the case at the conclusion of the investigation.

18. The AdSS shall ensure that concerns are reported to the appropriate regulatory agency including:

    a. The Department of Child Safety,

    b. Adult Protective Services,

    c. Arizona Department of Health Services,

    d. The Attorney General's Office,

    e. Law enforcement,

    f. AHCCCS Office of the Inspector General,

    g. The Division,

    h. Other entities as necessary.

19. The AdSS shall submit the initial report to the regulatory agency

in the format required by the regulatory agency as soon as possible but no later than 24 hours of becoming aware of a concern.

20. The AdSS shall submit to the Division all pertinent information regarding an incident of abuse, neglect, exploitation, serious incident, including suicide attempts, unexpected death, including all unexpected transplant deaths, and other serious incidents as determined by the Division or AHCCCS, via a written Incident Report to the Division no later than 24 hours after becoming aware of the incident.

    a. The AdSS shall not limit pertinent information to autopsy results;

    b. The AdSSS shall include a broad review of all issues and possible areas of concern.

    c. The AdSS shall not delay the Investigation of QOC Concern based on delays in receipt of autopsy.

    d. The AdSS shall, when available, use delayed autopsy results to confirm the resolution of the QOC Concern.

e. The AdSS shall follow procedures for reporting incidents, accidents, and deaths as specified in AdSS Medical Policy 961.

21. Upon receipt of an IAD Report from providers, the AdSS shall take action necessary to ensure the safety of the persons involved in the incident.

22. The AdSS shall review the IAD within one business day24 hours of receipt and make a determination of whether the incident includes a QOC Concern.

    a. The AdSS shall review the IAD Form to ensure it is fully and accurately completed. If an IAD is returned to the provider for corrections, the AdSS shall ensure that the provider returns the corrected version of the report within one business day of receipt.

23. The AdSS shall document all referrals made to a regulatory agency in the AHCCCS QM Portal and include, at a minimum, the following information:

    a. Name and title of the person submitting the report.

b. Name of the regulatory agency the report was submitted to.

c. Name and title of the person at the regulatory agency receiving the report.

d. Date and time reported.

e. Summary of the report.

f. Tracking number, as applicable, received from the regulatory agency as part of the reporting process.

24. The AdSS shall have a process to refer issues to the AdSS' Peer Review Committee when appropriate.

a. The AdSS shall ensure that appropriate referrals include all high-profile cases.

b. The AdSS shall not consider a referral to the Peer Review Committee as a substitute for implementing interventions aimed at individual and systemic quality improvement.

25. The AdSS shall document in the QOC file within the AHCCCS QM Portal Peer Review referrals as well as high-level summary information and must include documentation of the specific

credentials of the involved Committee members.

26. If an adverse action is taken with a provider for any reason including those related to a QOC Concern, the AdSS shall report the adverse action,including limitations and terminations, and the rationale for the adverse action to the Division's QM Unit within 24 hours of the determination to take an adverse action and to the National Practitioner Data Bank as specified in the Division contract.

27. The AdSS shall ensure continuity of care, health and safety, and Member well being in transition of care when acting on adverse actions.

    a. The AdSS shall allow adequate time for identification of new providers, transition of Members to those providers, impact to Members, and timely communication to Members to prepare for a transition.

28. While there may be instances where a move or transition must occur quickly, the AdSS shall work with the Division to ensure Member needs are met without potential gaps in care or service delivery and without treatment disruption.

29. The AdSS shall document the closure of the review or investigation within the AHCCCS QM Portal.

30. The AdSS shall document all follow-up actions or monitoring activities as well as related observations or findings in the QOC file.

31. The AdSS shall notify the Division's QM Unit as specified in contract and take appropriate action with the provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to:

    a. Check the CSPMP

    b. Coordinate care with other prescribers

    c. Refer for substance use treatment or pain management.

32. The AdSS shall present the case finding m, as appropriate, to the AdSS' Peer Review Committee for review and recommendation to the QM/PI Committee for discussion and recommendations to AdSS leadership.

33. The AdSS shall present findings to the AdSS' Credentialing

Committee in the event that the case finding may have a direct impact on the credentialing or recredentialing of a provider.

C. TRAINING, INTER-RATER RELIABILITY FOR INCIDENT AND QOC REVIEW

1. The AdSS shall provide training to QM clinical staff on QOC investigations prior to performing these investigations.
    a. All clinical staff that may perform investigations onsite shall complete training on how to conduct the investigation and avoid interference with substantiation and/or prosecution.
    b. All clinical staff that may investigate alleged incidents in skilled nursing facilities, assisted living facilities, and behavioral health residential settings shall complete training on how to conduct investigations considering the specific needs of individuals with intellectual and developmental disabilities.

b. The AdSS shall incorporate AHCCCS Medical Manual Policy 960 Attachment D guidance in the content requirements for its training for investigations involving individuals with intellectual and developmental disabilities.

c. The AdSS shall perform Inter-Rater Reliability (IRR) testing for all staff making determinations related to incidents and QOC Concerns.

d. The AdSS shall perform the testing annually with a required passing grade of 90 percent.

e. The AdSS shall use test scenarios pertinent to its covered membership and approved by its Chief Quality Officer and Medical Director.

f. The AdSS shall require staff members who do not receive a passing grade of 90% to retake the exam a second time.

g. The AdSS shall develop and implement an education plan for staff members who do not attain a passing grade of 90 percent on the repeat testing until a passing grade is achieved or the staff member is reassigned to a different position for which the training requirement is not pertinent.

D. TRACKING AND TRENDING OF QOC AND SERVICE COMPLAINTS

1. The AdSS shall conduct oversight through tracking and trending of Member and provider concerns and making appropriate

referrals for independent review as described in this section.

2. The AdSS shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from Members and providers or as requested by the Division or AHCCCS, inclusive of quality care, immediate jeopardy, quality of service and immediate care need issues.

3. The AdSS shall analyze and evaluate the data from the tracking and trending system to identify and address any trends related to Members, providers, the QOC process, or services in the AdSS' service delivery system or provider network.

    a. The AdSS shall incorporate trending of Quality of Care issues in determining systemic interventions for quality improvement.

    b. The AdSS shall submit tracking and trending information to the Division to be reviewed and considered for action by the Division's Quality Management Unit and Chief Medical Officer, as Chairman of the QM/PI Committee.

4. If significant negative trends are noted in the tracking and

trending, the AdSS shall develop performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process. Tracking and trending may also identify promising practices that resulted in better outcomes for Members.

a. The AdSS shall report the results of performance improvement activities in (6) of this Section to the Division.

b. The AdSS shall refer QOC Concerns and opportunities for improvement identified through tracking and trending to the following committees, as appropriate:

i. QM/PI Committee, established in accordance with AdSS Medical Policy 910.

ii. Peer Review Committee, established in accordance with AdSS Medical Policy 910.

iii. Mortality Review Committee.

iv. Independent Oversight Committees established

pursuant to A.R.S. § 41-3801.

c. The AdSS shall make Member records availability and accessibility in compliance with federal and state confidentiality laws, including Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR 431.300 et seq.

d. The AdSS shall maintain information related to coverage and payment issues for at least five years following final resolution of the issue and must be made available to the Member, provider, Division, or AHCCCS authorized staff upon request.

e. The AdSS shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS program.

f. The AdSS' care coordination staff shall work with the Division's Support Coordination staff to facilitate and address Member complaints as a proactive measure to promote better service delivery and health outcomes.

E. PEER REVIEW COMMITTEE

1. The AdSS shall refer QOC Concerns to the AdSS' Peer Review Committee when appropriate.
    a. The AdSS shall not consider referral to the Peer Review Committee as a substitute for implementing interventions aimed at individual and systemic quality improvement.
    b. The AdSS shall document Peer Review Committee referrals and high-level summary information in the QOC file within the AHCCCS QM Portal and must include documentation of the specific credentials of the involved Committee members.
    c. The Peer Review Committee may include the following recommendations as applicable:
        i. Education/training/technical assistance
        ii. Follow-up monitoring and evaluation of improvement
        iii. Changes in processes, organizational structures, forms

iv. Informal counseling

v. Termination of affiliation, suspension, or limitation of the provider (if an adverse action is taken with a provider the AdSS reports the adverse action to the Division within one business day)

vi. Referrals to regulatory agencies

vii. Other actions as determined by AdSS

d. If an adverse action is taken with a provider for any reason including those related to a QOC Concern, the AdSS shall report the adverse action, including limitations and terminations, to the Division Quality Management Unit as well as to the National Practitioner Data Bank as specified in contract in accordance with AdSS Medical Manual Policy 950.

2. The AdSS shall notify the Division and take appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards

when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues, other prescribers, or referral for substance use treatment or pain management.

3. The AdSS shall present the findings related to (2) of this Section to, as appropriate, the AdSS' Peer Review Committee and Credentialing Committee for review and recommendations to the QM/PI Committee for discussion and recommendations to AdSS leadership.

F. REPORTING TO INDEPENDENT OVERSIGHT COMMITTEE

1. The AdSS shall provide Incident, Accident, and Death (IAD) Reports, Internal Referral (IRF) reports and Quality Of Care Concerns including, reports of possible abuse, neglect, or denial of rights involving any DDD enrolled Member to the DDD Independent Oversight Committee (IOC), established by A.R.S.§ 41-3801 and as outlined in this policy within three business days.
2. The AdSS shall incorporate IADs and IRFs that are triaged as potential QOC Concerns into the QOC record and shall submit to

the IOC as part of the QOC documentation upon completion of the QOC investigation in place of a standalone IAD/IRF within three business days of completion of the investigation.

3. The AdSS shall redact all PII from reports provided to the IOC in accordance with federal and state confidentiality laws.
4. The AdSS shall provide the IOCs Member information and records in accordance with A.R.S. §41-3804.
5. The AdSS shall provide Seclusion and Restraint Reports, IAD Reports, IRF reports and QOC reports including reports of possible abuse, neglect, or denial of rights involving any behavioral health to the IOC's as specified in the Division contract.
6. If a QOC investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS shall provide the requested documentation to the IOC via the AHCCCS Quality Management Portal.
7. The AdSS who receive an IOC request for additional or unaltered documentation, supplemental information, or an investigation regarding an AHCCCS Member, shall submit the request to

AHCCCS via email at: iocinquiries@azahcccs.gov.

G. REQUESTS FOR PII OR PHI

1. The AdSS shall only release PII or PHI concerning a currently or previously enrolled Member to the IOC if:

   a. The IOC demonstrates that the information is necessary to perform a function that is related to the oversight of the behavioral health system, or

   b. The IOC has written authorization from the Responsible Person to review PII or PHI.

2. If the AdSS determines that the IOC needs PII or PHI and has obtained the Responsible Person's written authorization, the AdSS shall first review the requested information and determine if any of the following types of information are present: Communicable disease related information, including confidential HIV information, information concerning diagnosis, treatment or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804.

   a. If no information detailed in (2) of the Section is found,

the AdSS shall provide the information adhering to the requirements of this policy.

b. If information detailed in (2) of this Section is found, the AdSS shall contact the Responsible Person, ask if the Responsible Person is willing to sign an authorization for the release of communicable disease related information, including confidential HIV information, information concerning diagnosis, treatment or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804 and provide the name and telephone number of a contact person with the IOC who can explain the Committee's purpose for requesting the protected information.

i. If the Responsible Person agrees to give authorization, the AdSS shall obtain written authorization as outlined below and provide the requested information to the IOC.

ii. If the Responsible Person does not agree to give authorization, the information is not included or is redacted from any documentation which is

authorized to be disclosed.

3. The AdSS shall accept authorization for the disclosure of records of deceased Members made by the executor, administrator, or other personal representative appointed by will or by a court to manage the deceased Member's estate. If no personal representative has been appointed, the AdSS shall upon request disclose PII and PHI to a family Member, other relative, or a close personal friend of the deceased Member, or any other person identified by the deceased, only to the extent that the PHI is directly relevant to such person's involvement with the deceased Members health care or payment related to the individual's health care,

4. The AdSS shall provide requested information that does not require authorization within 15 working days of the request.

5. The AdSS shall provide the requested information that does require authorization within five working days of receipt of the written authorization.

6. When PII or PHI is sent, the AdSS shall include a cover letter addressed to the IOC that states that the information is

confidential, is for the official purposes of the Committee, and is not to be re-released under any circumstances.

7. If the AdSS denies the IOC request for PII or PHI:

   a. The AdSS shall notify the IOC within five working days that the request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division Director, or designee, review this decision.

   b. The Committee's request to review the denial must be received by the Division Assistant Director, or designee, within 60 days of the first scheduled committee meeting after the denial decision is issued,

   c. The AdSS shall refer the IOC to Division Medical Manual 960 for the process of review by the Division Assistant Director, or designee.

H. AUTHORIZATION REQUIREMENTS

1. The AdSS shall only accept a written authorization for disclosure of information concerning diagnosis, treatment, or referral from

an alcohol or substance use program or communicable disease related information, including confidential HIV information, that contains the following information:

a. The specific name or general designation of the program or person permitted to make the disclosure.

b. The name or title of the individual or the name of the organization to which the disclosure is to be made.

c. The name of the currently or previously enrolled Member.

d. The purpose of the disclosure.

e. How much and what kind of information is to be disclosed.

f. The signature of the Responsible Person of a currently or previously enrolled Member.

g. The date on which the authorization is signed.

h. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

i. The date, event, or condition upon which the authorization

will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given.

j. A statement that this information has been disclosed from records protected by federal confidentiality rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the Member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H).

I. DUTIES AND LIABILITIES OF BEHAVIORAL HEALTH PROVIDERS IN PROVIDING BEHAVIORAL HEALTH SERVICES

1. The AdSS shall develop and make available written policies and procedures that provide guidance regarding the provider's duty to warn under A.R.S. § 36-517.02 which supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law.

2. The AdSS shall incorporate the following in policies, procedures,

and provider training related to (1) of this Section:

a. With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless *both* of the following occur:

   i. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

   ii. The mental health provider fails to take reasonable precautions.

b. A.R.S. § 36-517.02 provides that any duty of a behavioral provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

   i. Communicates, when possible, the threat to all

identifiable victims,

ii. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,

iii. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or

iv. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.

c. That this statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a Member under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a Member when a Member has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a Member is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the

Member to reduce the risk of harm.

d. That all providers, regardless of their specialty or area of practice, have a duty to protect others against a Member's potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined that a Member poses a serious danger to self or others, the provider must exercise care to protect others against imminent danger of a Member harming him/herself or others. The foreseeable victim need not be specifically identified by the Member, but he/she may be someone who would be the most likely victim of the Member's dangerous conduct.

e. That the responsibility of a behavioral health provider to take reasonable precautions to prevent harm threatened by a Member may include any of the following:

i. Communicating, when possible, the threat to all identifiable victims,

ii. Notifying a law enforcement agency in the

vicinity where the Member or any potential victim resides,

iii. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U, or

iv. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

J. PROVIDER-PREVENTABLE CONDITIONS

1. The AdSS shall not provide payment for services related to provider preventable conditions.

2. If the AdSS identifies a Provider-Preventable Conditions, the AdSS shall:

   a. Conduct a QOC investigation within the AHCCCS QM Portal.

   b. Report the occurrence and results of the investigation to the Division's QM Unit quarterly, as

specified in the Contract.

c. Report the occurrence to the appropriate regulatory boards and agencies in accordance with the provisions of this policy following the outcome of the investigation.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 08:27 PDT)
Anthony Dekker, D.O.

961 INCIDENT, ACCIDENT, AND DEATH REPORTING

REVISION DATE: 8/9/2023
EFFECTIVE DATE: May 11, 2022
REFERENCES: A.R.S. §8-201(2), §14-1501, §36.551.01, §46-451, §41-3801, §41-3803, §41-3804; A.A.C. R9-10-101, R9-21-105; AHCCCS Medical Policies 960, 962, 1020, AdSS Operations Policy 417.

PURPOSE

The purpose of the policy is to establish the Incident, Accident, and Death reporting requirements for the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) in a consistent manner across the delivery system.

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services.

Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

2. "AHCCCS" means Arizona Health Care Cost Containment System.
3. "Community Complaint" means a complaint from the community that puts a Member or the community at risk of harm.
4. "Death No Provider Present" means death of a Member living independently or with family and no Provider is being paid for service provision at the time of death.
5. "Expected Death" means natural death, and may include deaths from long-standing, progressive medical conditions or age-related conditions.
6. "High Profile Case" means a case that attracts or is likely to attract attention from the public or media.
7. "Human Rights Violation" means a violation of a Member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the state of Arizona. Human Rights are defined in A.R.S. §36.551.01 as a violation of a Member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat, etc.

8. "Incident, Accident, Death" means an unexpected occurrence that harms or has the potential to harm a Member and is:
   a. On the premises of a health care institution, or
   b. Not on the premises of a health care institution and directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution as specified in A.A.C. R9-10-101.
9. "Independent Oversight Committee" is a committee established by State Statute to provide independent oversight and to ensure the rights of certain individuals with developmental disabilities and persons who receive behavioral health services are protected as defined in A.R.S. §§41-3801, 41-3803, 41-3804, and A.A.C. R9-21- 105.
10. "Medication Error" means that one or more of the following has occurred:
    a. Medication given to the wrong person,
    b. Medication given at the wrong time or not given at all,
    c. Wrong medication dosage administered,
    d. Wrong method of medication administration, or
    e. Inappropriate wastage of a Class II substance.

11. “Member” means the same as “Client” as defined in A.R.S. § 36-551.
12. “Physical Abuse” means intentional infliction of pain or injury to a Member.
13. “Programmatic Abuse” means aversive stimuli techniques not approved as part of a Member’s plan. This can include isolation, restraints, or not following an approved plan or treatment strategy.
14. “Provider” means, for the purpose of this Policy, any individual or entity that is engaged in the delivery of services to Division Members, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
15. “Sentinel Event” means an unexpected event that results in the death of a member, serious physical injury of a member, or severe psychological harm of a member, and requires an immediate investigation and response.
16. “Serious Injury” means any type of injury requiring medical care or treatment beyond first aid, such as assessment or treatment in an emergency room, treatment center, physician’s office, urgent care or admission to a hospital.
17. “Sexual Abuse” means any inappropriate interactions of a sexual

nature toward or solicited from a Member with developmental disabilities.

18. "Unexpected Death" means a sudden death and may include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma, sudden deaths from undiagnosed conditions, or generic medical conditions that progress to rapid deterioration.

19. "Verbal/Emotional Abuse" means remarks or actions directed at a Member that are ridiculing, demeaning, threatening, derogatory, or profane.

POLICY

A. MINIMUM REQUIREMENTS FOR IAD REPORTING

1. The AdSS shall develop a process to ensure High Profile, media, and Sentinel events affecting members can be reported to the AdSS by Providers, Members, or a Member's family, at any time, 24 hours a day, seven days a week, and that these communications are provided to the AdSS Quality Management Department.

2. The AdSS shall ensure that reportable IADs and Internal Referrals are submitted within two business days of the occurrence or notification to the AdSS of the occurrence via the AHCCCS Quality Management (QM) Portal.

3. The AdSS shall ensure Sentinel IADs are submitted via the AHCCCS QM Portal within one business day of the occurrence or becoming aware of the occurrence.

4. The AdSS shall notify the Division and AHCCCS of all sentinel events via email at dddcareconcerns@azdes.gov and CQM@ahcccs.gov immediately, but within 24 hours of notification of the occurrence.

5. The AdSS shall report IADs that include any of the following:
    a. Allegations of abuse, neglect, or exploitation of a Member.
    b. Allegations of Human Rights Violations.
    c. Substance use disorders or opioid-related concerns.
    d. Death of a Member.
    e. Delays or difficulties in accessing care outside of the timeline specified in the AdSS Operations Policy 417.
    f. Healthcare acquired conditions and other provider

preventable conditions as specified in AdSS Medical Policy 960.

g. Serious Injury.

h. Injury resulting from the use of a personal, physical, chemical, or mechanical restraint or seclusion as specified in Division Medical Policy 962.

i. Medication Error occurring at a licensed residential Provider site including:

i. Division Group Home,

ii. Division Adult Developmental Home,

iii. Child Developmental Home,

iv. Assisted Living Facility,

v. Skilled Nursing Facility,

vi. Behavioral Health Residential Facility,

vii. Adult Behavioral Health Therapeutic Home,

viii. Therapeutic Foster Care Home, or

ix. Any other alternative Home and Community Based Service setting as specified in Division Medical Policy 1230-A.

j. Member missing from a licensed Behavioral Health

Inpatient Facility, Behavioral Health Residential Facility, Division Group Home, Assisted Living Facility, Skilled Nursing Facility, Adult Behavioral Health Therapeutic Home, or Therapeutic Foster Care.

k. Member suicide attempt.

l. Suspected or alleged criminal activity involving or affecting a Member.

m. Community Complaint about a resident or the setting.

n. Provider or Member fraud.

o. Allegations of Physical, Sexual, Programmatic, Verbal/Emotional Abuse.

p. Allegations of inappropriate sexual behavior.

q. Theft or loss of Member monies or property less than $1,000.

r. Property damage estimated to be less than $10,000.

s. Community disturbances in which the Member or the public may have been placed at risk.

t. Environmental circumstances which pose a threat to the health, safety, or welfare of Members such as loss of air conditioning, loss of water, or loss of electricity.

u. Unplanned hospitalization or emergency room visit in response to an illness, injury, Medication Error.

v. Unusual weather conditions or other disasters resulting in an emergency change of operations impacting the health and safety of a Member.

w. Illegal substance use by Provider or Member.

x. Any other incident that causes harm or has the potential to cause harm to a Member.

6. The AdSS shall report IADs as a Sentinel Event if they include any of the following:

a. Member death or Serious Injury associated with missing Member.

b. Member suicide, attempted suicide, or self-harm that results in Serious Injury, while being cared for in a healthcare setting.

c. A 9-1-1 call due to a suicide attempt by a Member.

d. Member death or Serious Injury associated with a Medication Error.

e. Member death or Serious Injury associated with a fall while

being cared for in a healthcare setting.

f. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting or any other setting where the AdSS has oversight responsibility.

g. Member death or Serious Injury associated with the use of seclusion or restraint while being cared for in a healthcare setting.

h. Sexual Abuse or assault of a Member during the provision of services.

i. Death or Serious Injury of a Member resulting from a physical assault that occurs during the provision or services.

j. Homicide committed by or allegedly committed by a Member.

k. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a Member or staff.

l. Severe physical injury that does any of the following:

   i. Creates a reasonable risk of death,

ii. Causes serious or permanent disfigurement, or

iii. Causes serious impairment of a Member's or worker's health.

m. Reporting to law enforcement officials because a Member is missing and presumed to be in imminent danger.

n. Reporting to law enforcement officials due to possession or use of illegal substances by Members or Providers.

o. An incident or complaint from the community that could be or is reported by the media.

p. Property damage estimated in excess of $10,000.

q. Theft or loss of Member monies or property in excess of $1,000.

7. The AdSS shall develop a process to conduct an initial review of all IADs within one business day of Provider submission. An initial review shall include the following:

a. Identification of any immediate health and safety concerns and ensure the safety of the individuals involved in the incident, which may include that immediate care and recovery needs are identified and provided.

b. Determination if the IAD report needs to be returned to

the Provider for additional information, to correct inaccurate information, or to provide missing information.

c. Determination if the IAD report requires further investigation through a quality of care investigation as specified in AdSS Medical Policy 960.

d. Determination if the IAD needs to be linked to a corresponding Seclusion and Restraint Individual Reporting Form.

e. Determination that the IAD report does not need further documentation or review, and closure of the report.

8. The AdSS shall follow up on all IADs returned to the Provider within one business day to ensure the Provider is aware that the report has been returned and is addressing the required corrections.

9. The AdSS shall take immediate action to ensure the safety of Members where allegations of harm or potential harm exists, regardless of status assigned to the IAD, including those returned to a Provider.

10. The AdSS shall report suspected cases of abuse, neglect, or

exploitation of a Member to the appropriate reporting authorities, if not reported directly by the Provider as specified in Division Operations Policy 6002-G.

11. The AdSS shall track and trend all IADs to identify and address systemic concerns or issues within their Provider network.

12. The AdSS shall submit reports to the Division describing the track and trend activities, as well as any systemic concerns or issues identified and how they were addressed.

13. The AdSS shall provide IAD reports to the appropriate Independent Oversight Committees as specified in AdSS Medical Policy 960.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 13:21 PDT)
Anthony Dekker, D.O.

962 REPORTING AND MONITORING OF SECLUSION & RESTRAINT

REVISION DATE: 8/9/2023

EFFECTIVE DATE: July 6, 2022

REFERENCES: A.A.C. R9-10-101, R9-10-225, R9-10-226, R9-10-316, R9-10-1012, R9-21-101, R9-21-204, A.R.S. §36-501, §41-3804(K), 42 CFR 482.13(e)(1)(i)(B), AdSS Medical Policies 960 and 961

PURPOSE

This Policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS). The purpose of this policy is to establish requirements for reporting and monitoring the use of Seclusion and Restraint (SAR) involving Members with intellectual and developmental disabilities enrolled in a Division subcontracted health plan.

DEFINITIONS

1. "Behavioral Health Inpatient Facility" means, as defined in A.A.C. R9-10-101, a health care institution that provide continuous treatment to individuals experiencing behavioral health issues that cause that individual to:
    a. Have a limited or reduced ability to meet the basic physical needs;

b. Suffer harm that significantly impairs the judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self or others;

d. Be persistently or acutely disabled as defined in A.R.S. §36-501; or

e. Be gravely disabled.

2. "Incident of Seclusion and Restraint" means an occurrence of Seclusion or Restraint that begins at the time a behavior necessitating Seclusion or Restraint begins and ends when the behavior has resolved for more than ten minutes.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Mental Health Agency" means a regional authority, service provider, inpatient facility, or outpatient treatment center licensed to provide behavioral health observation/stabilization services (Crisis Facility), licensed to perform Seclusion and Restraint as specified in A.A.C R9-10-225, A.A.C. R9- 10-226, A.A.C. R9-10-316 and A.A.C. R9-10-1012.

5. "Personally Identifiable Information" means a person's name, address, date of birth, social security number, tribal enrollment number,

telephone or fax number, email address, social media identifier, driver license number, places of employment, school identification or military identification number, or any other distinguishing characteristic that tends to identify a particular person as specified in A.R.S. §41-3804 (K).

6. "Restraint" means personal Restraint, mechanical Restraint, or drug used as a Restraint, and is the following:
   a. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a Member to move their arms, legs, body, or head freely.
   b. A drug or medication when it is used as a restriction to manage a Member's behavior or restrict the Member's freedom of movement and is not a standard treatment or dosage for the Member's condition.
   c. A Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a Member for the purpose of conducting routine physical examinations or tests, or to protect the Member from falling out

of bed or to permit the Member to participate in activities without the risk of physical harm. This does not include a physical escort.

7. "Seclusion" means the involuntary solitary confinement of a Member in a room or an area where the Member is prevented from leaving as specified in A.A.C. R9-10-101.

8. "Seclusion of Members Determined to Have A Serious Mental Illness" means the restriction of a Member to a room or area through the use of locked doors, or any other device or method which precludes a Member from freely exiting the room or area, or which a Member reasonably believes precludes their unrestricted exit as specified in A.A.C. R9-21-101(B).

   a. In the case of an inpatient facility, confining a Member to the facility, the grounds of the facility, or a ward of the facility, does not constitute Seclusion.

   b. In the case of a community residence, restricting a Member to the residential site, according to specific provisions of a service plan or court order, does not constitute Seclusion, as specified in A.A.C. R9-21-101(B).

POLICY

A. SECLUSION AND RESTRAINT

1. Seclusion and Restraint (SAR) shall only be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R9-10-316 and A.A.C. R9-21-204.

2. The AdSS shall develop written policies and procedures for reporting individual reports of SAR involving Members receiving services in Behavioral Health Inpatient Facilities or Mental Health Agencies as specified in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy 962.

3. The AdSS shall develop written policies and procedures to monitor and ensure compliance of its behavioral health providers with SAR policies, procedures, and reporting requirements.

4. The AdSS shall report the use of SAR as described in this policy to the AHCCCS Division of Community Advocacy and Intergovernmental Relations, Office of Human Rights (OHR), and the appropriate Independent Oversight Committee (IOC) via collaboration with the AHCCCS Division of Health Care Management, Quality Management (QM) IOC Manager.

B. REPORTING REQUIREMENTS

1. The AdSS shall ensure that Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies providing services to Division Members, that are authorized to use SAR as specified in A.A.C. R9-21-101, A.A.C. R9-10-225, A.A.C. R9-10-316 and R9-10-1012, follow the reporting requirements specified in this policy.

2. The AdSS shall ensure that any out-of-state facility used to provide services to a Member agrees to and follows all reporting requirements as specified within this policy as a part of the contracted single case agreement.

3. The AdSS shall ensure that BHIFs and Mental Health Agencies submit individual reports of Incidents of SAR involving any Division Member enrolled in a subcontracted health plan directly to the AdSS within five days of the incident using AMPM 962 Attachment A or the agency's electronic medical record that includes all elements listed on Attachment A. If the use of SAR requires face-to-face monitoring, as specified in A.A.C.

R9-21204, a supplemental report shall be submitted to the AdSS as an attachment to the individual report.

4. The AdSS shall ensure that BHIFs and Mental Health Agencies report incidents of SAR that result in an injury to the AdSS within 24 hours of the incident.

C. SUBMITTING INDIVIDUAL REPORTS OF SAR TO THE AHCCCS QM PORTAL

1. The AdSS shall submit individual reports of SAR in the AHCCCS QM Portal as specified in contract. The AdSS shall ensure that the original AMPM 962 Attachment A or electronic medical record received from the behavioral health provider is attached to the report within the AHCCCS QM Portal.

2. The AdSS shall review each Incident of SAR and link the report to any connected Incident, Accident, or Death (IAD), Internal Referral (IRF), or Quality of Care (QOC) Concern process within the AHCCCS QM Portal at QMportal.azahcccs.gov as specified in AdSS Medical Policy 960.

D. AdSS REQUIREMENTS FOR SUBMITTING SAR REPORTS TO THE IOC

1. The AdSS shall ensure that all individual SAR reports involving behavioral health providers are uploaded for IOC review as specified in contract.

2. The AdSS shall ensure that reports uploaded for IOC review have all Personally Identifiable Information removed prior to submission as specified in A.R.S. §41-3804. If the use of SAR requires face-to-face monitoring, as outlined in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to each individual report.

3. AdSS shall ensure that the disclosure of protected health information is in accordance with state and federal laws.

E. OVERSIGHT, MONITORING, TRACKING AND TRENDING

1. The AdSS shall ensure Member safety, appropriate use of SAR, reporting compliance by network providers, and the disclosure of protected health information is in accordance with state and federal laws through regular monitoring and oversight

activities.

2. The AdSS shall review all SAR reports and QOC Concerns involving the inappropriate use of SAR to identify opportunities for improvement and make recommendations to the appropriate committee as applicable.

3. The AdSS shall review and track and trend the use of SAR for all Members enrolled in the subcontracted health plan.

4. The AdSS shall report any identified trends on the use of SAR to the Division.

5. The AdSS shall submit all reports as specified in contract to the Division and participate in the Annual Operational Review.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 12:44 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

1. The AHCCCS OHR and the IOCs review SAR reports to determine if there has been inappropriate or unlawful use of SAR and to determine

if SAR may be used in a more effective or appropriate fashion.

2. If the AHCCCS OHR or any IOC determines that SAR has been used in violation of any applicable law or rule, the AHCCCS OHR or IOC may take whatever action is appropriate in accordance with their applicable regulation(s) and, if applicable, A.A.C. R9-21-204.

963 PEER AND RECOVERY SUPPORT SERVICE PROVISION REQUIREMENTS

REVISION DATES: 4/10/2024, 12/21/2022, 6/8/2022

REVIEW DATE: 8/15/2023

EFFECTIVE DATE: October 1, 2020

REFERENCES: A.R.S. § 32- 3251, A.R.S. Title 32, Chapter 33, A.R.S. § 36-501, A.R.S. § 32-2061, A.R.S. § 32-2091, A.A.C. R4-6-101, A.A.C. R9-10-101, AMPM 320-Q, AMPM 963; Attachment A-C, AMPM 965

PURPOSE

This policy establishes requirements for the provision of Peer Support services within the Administrative Services Subcontractors (AdSS) programs, including qualifications, supervision, continuing education, and training/credentialing of Peer and Recovery Support Specialists (PRSS). The requirements in this policy are delegated to the AdSS and the Division of Developmental Disabilities (Division) does not perform these functions. The Division oversees the AdSS and ensures implementation and compliance of all requirements in this policy, including reserving the right to assess compliance with these requirements during the Division's annual operational review of each AdSS.

DEFINITIONS

1. "Behavioral Health Paraprofessional" or "BHPP" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures, as specified in A.A.C. R9-10-101(28).
    a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
    b. Are provided under supervision by a behavioral health professional.
2. "Behavioral Health Professional" or "BHP" means
    a. An individual licensed under A.R.S. § 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health as specified in A.R.S. § 32-3251, or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as specified

in A.R.S. § 32-3251 under direct supervision as specified in A.A.C. R4-6-101.

b. A psychiatrist as specified in A.R.S. § 36-501.

c. A psychologist as specified in A.R.S. § 32-2061.

d. A physician.

e. A behavior analyst as specified in A.R.S. § 32-2091.

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services.

3. "Behavioral Health Technician" or "BHT" means an individual who is not a behavioral health professional who provides behavioral health services to a patient to address the patient's behavioral health issue:

a. With clinical oversight by a BHP, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed as specified in A.R.S. § 32, Chapter 33; and

b. Health-related services.

4. "Credential" for purposes of this policy, means a written document issued by a Peer Support Employment Training Program ("PSETP"), or by a state, demonstrating compliance with all qualifications and training requirements in this policy.

5. "Health Insurance Portability and Accountability Act" or "HIPPA" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

7. "Office of Individual and Family Affairs (OIFA) Alliance" means a collaborative of all OIFAs in Arizona, including AHCCCS OIFA.
8. "Peer-And-Recovery Support" means a distinct health care practice involving intentional partnerships to provide social and emotional support, based on shared experiences of living with behavioral health disorders, Substance Use Disorders, or other traumas associated with significant life disruption. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.
9. "Peer-And-Recovery Support Specialist" or "PRSS" means an individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS programs.
10. "Peer-and-Recovery Support Specialist" or "PRSS" "Continuing Education and Ongoing Learning" means activities of professional development intended to enhance relevant knowledge and build skills within a given practice. These activities may involve, but are

not limited to, acquiring traditional Continuing Education Units (CEUs).

11. "Peer-and-Recovery Support Specialist" or "PRSS" Credential" means a written document issued to a qualified individual by operators of an AHCCCS-recognized PRSS credentialing program, a PRSS Credential which is necessary for provision of Medicaid-reimbursed Peer Support services delivered by the holder of the Credential under supervision by a Behavioral Health Technician of Behavioral Health Professional.
12. "Peer Support Employment Training Program" or "PSETP" means a training program that is in compliance with requirements in this policy through which qualified individuals are credentialed as PRSS by completing training and passing a competency exam.
13. "Self-Help/Peer Services" or "Peer Support" means supports intended for enrolled Members or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
14. "Substance Use Disorder" or "SUD" means a range of conditions

that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

POLICY

A. PEER SUPPORT SERVICES

1. The AdSS shall comply with Centers for Medicare and Medicaid Services (CMS) requirements for delivery of Peer Support services as specified in the State Medicaid Director Letter, SMDL #07-011, the AHCCCS/Division of Community Advocacy and Intergovernmental Relations (DCAIR), Office of Individual and Family Affairs (OIFA), that has established training requirements and credentialing standards for Peer and Recovery Support Specialist (PRSS) providing Peer Support within the AHCCCS programs.
2. The AdSS shall provide services to an individual, group, or family, that are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

B. PEER AND RECOVERY SUPPORT SPECIALIST AND TRAINER QUALIFICATIONS

1. The AdSS shall require PSETP operators to ensure individuals seeking credentialing and employment as a PRSS meet the following criteria:
    a. Qualify as a BHPP, BHT, or BHP;
    b. Consent to sharing their PRSS Credential with the Contractor and AHCCCS registered providers for verifying compliance with this Policy; and
    c. Self-identify as an individual who:
        i. Has their own lived experience of mental health conditions, or substance use, for which they have sought support; and
        ii. Has an experience of sustained recovery to share.
2. The AdSS shall require individuals facilitating training hold a PRSS Credential from an AHCCCS-recognized PSETP.
3. The AdSS PSETP operators shall:
    a. Permit only individuals holding a PRSS Credential to facilitate training;
    b. Utilize Attachment B to determine if applicants are qualified for admission;
    c. Admit only individuals completing and fulfilling all

requirements of Attachment B; and

d. Obtain consent from trainees to share their PRSS Credentials with the Contractor and AHCCCS registered providers for verifying compliance with this Policy.

4. The AdSS shall require the operator to only admit individuals completing and fulfilling all requirements of AMPM policy 963 Attachment B.

5. The AdSS shall require the PSETP operator to:

   a. Make the final determination for admission;

   b. Maintain copies of all issued PRSS Credentials; and

   c. Provide replacement Credentials to graduates upon request.

6. The AdSS and providers shall recognize credentialing from any PSETP in compliance with this Policy. If there are regional, agency or culturally specific training requirements exclusive to the AdSS, service provider or tribal community, the additional requirements shall not prevent recognition of a PRSS Credential issued in compliance with this policy.

7. The PRSS credentialing process is not a behavioral health service.

C. COMPETENCY EXAM

1. The AdSS shall require, upon completion of required training,

individuals demonstrate their ability to support the recovery of others by passing a competency exam with a minimum score of 80%.

2. Each PSETP operator may develop a unique competency exam at the discretion of the PSETP.
3. The AdSS shall require all exams include questions related to each of the curriculum core elements as specified in this Policy.
4. The AdSS shall require individuals who do not pass the exam to complete additional training at the discretion of the PSETP operator prior to taking the exam again.
5. The AdSS shall permit the provider of the exam to make a retake exam available to individuals who do not pass the competency exam.
6. The AdSS shall require agencies employing PRSS and delivering Peer Support services to ensure staff receive training focused on working with the populations served.
7. The AdSS shall ensure all AHCCCS registered providers operating a PSETP submit, upon completion of each class, Attachment C to the AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov. These reports shall contain no other identifying information apart from

what is required.

8. The AdSS shall require PSETPs retain copies of Attachment C and make copies available to the Division upon request.

D. SUBMITTING EVIDENCE OF CREDENTIALING

1. The AdSS shall require contractors to ensure provider agencies contracted to deliver Peer Support services utilize Attachment A to maintain current and ongoing documentation verifying all individuals delivering Medicaid-reimbursed Peer Support services are in compliance with this policy;
2. The AdSS shall ensure employers of PRSS have defined qualifications for BHPPs and BHTs;
3. The AdSS Contractors shall develop and make available to providers policies and procedures describing how the AdSS is monitoring and auditing/oversight activities where records specific to supervision, training, continuing education, or ongoing learning of PRSS are reviewed and maintained; and
4. The AdSS Contractors shall submit Attachment A documenting all actively employed PRSS meet the required qualifications and credentialing for the delivery of Peer Support services as specified in the contract.

E. INTER-STATE RECIPROCITY

Individuals credentialed in another state shall submit their Credentials to AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov.

F. CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

1. The AdSS shall establish requirements for individuals employed as PRSS to obtain continuing education and ongoing learning relevant to Peer Support, including physical health and wellness.
2. The AdSS shall develop and make available to providers policies and procedures describing requirements for individuals employed as PRSS have access to and obtain a minimum of four hours of continuing education and ongoing learning relevant to Peer Support, per year, with at least one hour covering ethics and boundaries related to the practice of Peer Support.

G. SUPERVISION OF PEER AND RECOVERY SUPPORT SPECIALISTS

1. The AdSS shall require the individual providing the service has a PRSS Credential from an AHCCCS-recognized PSETP and receive supervision as specified in the Arizona Administrative Code in order to receive Medicaid reimbursement for Peer Support services.

2. The AdSS and FFS providers shall ensure:

   a. Providers have policies and procedures to establish the minimum professional, educational or experiential qualifications for BHPPs and BHTs;

   b. Provider policies and procedures establish the amount and duration of supervision for PRSS qualifying as BHPPs and BHTs;

   c. Supervision is documented and inclusive of both clinical and administrative supervision; and

   d. Supervisors of PRSS have access to training and ongoing learning relevant to the supervision of PRSSs and the delivery of Peer Support services.

H. PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS

The AdSS shall require a PSETP to include the following core elements in the credentialing program curriculum:

a. Concepts of Hope and Recovery:

   i. Instilling the belief that recovery is real and possible;

   ii. The history of social empowerment movements and

their connection to Peer and Recovery Support, including but not limited to the following movements:

a) Self-Help;

b) Consumer/Survivor/Ex-Patient;

c) Neurodiversity;

d) Disability Rights; and

e) Civil Rights.

iii. Varied ways that behavioral health has been viewed and treated over time and in the present;

iv. Appreciating diverse paradigms and perspectives of recovery and other ways of thinking about behavioral health, including Harm Reduction, 12-Step Recovery, and Neurodiversity and other approaches;

v. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways;

vi. Holistic approach to recovery addressing behavioral, emotional, and physical health; and

vii. Member driven/person centered service planning.

b. Advocacy and Systems Perspective:

i. State and national health systems' infrastructure including the history of Arizona's health systems;

ii. Confronting and countering discrimination, prejudice, bias, negative stereotypes, and other social injustices against those with behavioral health and Substance Use Disorders – combating internalized stigma and oppression;

iii. Organizational change - how to utilize person-first language and identity-first language to educate provider staff on recovery principles and the role and the value of Peer Support;

iv. Diversity, Equity, Inclusion and Accessibility (DEIA) for underserved and underrepresented communities;

v. Creating a sense of community in a safe and supportive environment;

vi. Forms of advocacy and effective strategies – consumer rights and navigating the health systems;

vii. The Americans with Disabilities Act (ADA); and

viii. Social Determinants of Health (SDOH).

c. Psychiatric Rehabilitation Skills and Service Delivery:

i. Strengths based approach, identifying one's own strengths, and helping others identify theirs;

ii. Building resilience;

iii. Trauma-Informed Care;

iv. Distinguishing between sympathy and empathy, and emotional intelligence;

v. Understanding learned helplessness, how it is taught and how to assist others in overcoming its effects;

vi. Motivational interviewing, communication skills and active listening;

vii. Healing relationships – building trust and creating mutual responsibility;

viii. Combating negative self-talk - noticing patterns and replacing negative statements about oneself, using mindfulness to gain self-confidence and relieve stress;

ix. Group facilitation skills;

x. Culturally & Linguistically Appropriate Services (CLAS) standards, and the role of culture in recovery; and

xi. Understanding and supporting individuals with

Intellectual and Developmental Disabilities (I/DD).

d. Professional Responsibilities of the PRSS and Self Care in the Workplace:

i. Professional boundaries and codes of ethics unique to the role of a PRSS.

ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA).

iii. Responsibilities of a mandated reporter; what to report and when to report.

iv. Understanding common signs and experiences of:

a) Mental health disorders;

b) Substance Use Disorders (SUD);

c) Opioid Use Disorder (OUD);

d) Addiction;

e) Dissociation;

f) Trauma;

g) I/DD; and

h) Abuse/exploitation and neglect.

v. Familiarity with commonly used medications and

potential side effects; informed consent as specified in AMPM Policy 320-Q, General and Informed Consent.

vi. Guidance on proper service documentation, billing and using recovery language throughout documentation.

vii. Self-care skills:

a) Coping practices for helping professionals;

b) The importance of ongoing supports for overcoming stress in the workplace;

c) Using boundaries to promote personal and professional resilience; and

d) Using self-awareness to prevent compassion fatigue, secondary traumatic stress, and burnout.

e. PSETPs shall not duplicate training requirements of individuals employed by a licensed agency or Community Service Agencies (CSA).

f. A PRSS employed in CSA shall complete additional training as specified in AMPM Policy 965.

g. The AdSS shall develop and make available policies and procedures as well as additional resources for development

and improvement of PSETP curriculum, including the AdSS staff contacts for questions or assistance to PSETP operators.

I. PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL

1. The AdSS shall require AHCCCS registered providers intending to operate a PSETPs to submit a completed PSETP application to OIFAAlliance@azahcccs.gov in order to be considered for review:
   a. If the application is denied the applicant may submit a new application, no earlier than six months after initial denial.
   b. If the application is accepted, the applicant shall follow OIFA Alliance instructions for submitting their program materials for further compliance review.
2. The AdSS shall require training curriculum materials to contain:
   a. Student and trainer manuals,
   b. Handouts,
   c. Homework,
   d. Final exam,
   e. Credentialing certificate,
   f. Any other classroom materials, and
   g. Description of reasonable accommodations and alternative formats for the accessibility of program materials by all

audiences.

3. The AdSS shall require a program that makes substantial changes including change to content, classroom time to its curriculum, or if there is an addition to required elements of the program, to submit the updated content to OIFAAlliance@azahcccs.gov for review and approval.
4. The AdSS shall ensure, if there are regional or culturally specific training requirements exclusive to the AdSS or tribal community, the additional training requirements shall not prevent employment or transfer of a PRSS Credential based on the additional elements or standards.
5. The AdSS shall require all AHCCCS-recognized PSETPs to make curriculum materials available to Members of the OIFA Alliance and/or AHCCCS DFSM upon request.
6. The AdSS shall have policies, procedures, and additional resources for curriculum development of PSETP.
7. The AdSS shall designate staff to respond to questions.
8. The AdSS shall identify a point of contact within the AdSS' OIFA who is authorized to assist and advise PRSS operators in further

developing and enhancing their PSTEPs curricula.

9. The AdSS shall establish a process through which PSTEPs curricula of PRSS operators are made available to the point of contact for review upon request.
10. The AdSS OIFA point of contact shall provide feedback to PRSS operators to develop and enhance their PSTEP curricula.
11. The AdSS OIFA shall have a process in which the curriculum development of PSETP are made available to the Division for review as specified in Section F, Attachment F3, Contractor Chart of Deliverables.
12. The AdSS shall require the PSETP curriculum to be emailed to the DDD OIFA Behavioral Health Advocate Supervisor at OIFABHAdvocate@azdes.gov.

SUPPLEMENTAL INFORMATION

1. The OIFA Alliance oversees the PSETP review process including the setting of requirements, terms and conditions for recognition. Members of the OIFA Alliance will determine all PSETP applications and evaluate all submitted training materials prior to issuing or withholding approval. AHCCCS/DCAIR OIFA bases approval solely on a program’s compliance

with all requirements as specified in this policy.

2. Peer Support employment training is not a billable service for costs associated with training the agency's own employees. PSETP providers shall follow the review process as specified below.
3. The OIFA Alliance determines approval of a PSETP based on the program's compliance with the curriculum Core Elements specified in Section H of this Policy. An AHCCCS recognition of an OIFA Alliance approval is necessary for PRSS Credentials issued by the PSETP to be in compliance with CMS SMDL #07-011.
4. The PRSS credentialing process, as described in this Policy, is not a behavioral health service. Compliance with this Policy is not permission to deliver any behavioral health services PSETP operators may associate with the PRSS credentialing process.
5. Peer support services are specified as Healthcare Common Procedure Coding System (HCPCS) H0038 and H2016 in the Behavioral Health Services Matrix on the AHCCCS website. These are further defined in AMPM Policy 310-B and the AHCCCS Contract and Policy Dictionary and are subject to billing limitations in the Fee-for-Service Provider Billing Manual.
6. A PRSS credential from an AHCCCS-recognized PSETP is necessary for

provision of Medicaid-reimbursed peer support services delivered by the holder of the credential under supervision by a Behavioral Heals Technician (BHT) or Behavioral Health Professional (BHP).

7. The intent of Peer Support services is the provision of assistance to utilize the service delivery system more effectively. Peer and Recovery Support also assists with the understanding and coping with stressors of the individual's disability through support groups, coaching, role modeling, and mentoring.

8. AHCCCS/DCAIR OIFA oversees the approval of all credentialing materials including curriculum and testing tools. AHCCCS/DCAIR OIFA bases approval solely on a program's compliance with all requirements as specified in this policy.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:49 PDT)
Anthony Dekker, D.O.

964 CREDENTIALED FAMILY SUPPORT PARTNER REQUIREMENTS

REVISION DATES: 2/7/2024, 12/21/2022, 6/8/2022, 10/1/2020

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: October 1, 2020

REFERENCES: 42 U.S.C. 126; 47 U.S.C. 5; A.A.C. R9-10-101; A.R.S.§32-3274; AMPM Policy 964; Attachment A-B; AdSS Medical Policy 963.

PURPOSE

This policy applies to Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS). This policy establishes requirements expected of each AdSS for training and credentialing standards for individuals seeking employment as a Credentialed Family Support Provider (CFSP) in AHCCCS programs.

DEFINITIONS

1. "Adult Recovery Team" or "ART" means a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's

assessment, service planning, and service delivery. At a minimum, the team consists of the Member, Member's Health Care Decision Maker (HCDM) if applicable, advocates if assigned, and a qualified behavioral health representative. The team may also include the Member's family, physical health, behavioral health or social service providers, other agencies serving the Member, professionals representing various areas of expertise related to the Member's needs, or other individuals identified by the Member.

2. "Americans With Disabilities Act" or "ADA" means the law passed by the Congress of the United States that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
3. "Behavioral Health Paraprofessional" or "BHPP" means as specified in A.A.C. R9-10-101.

4. "Behavioral Health Professional" or "BHP" means the same as specified in A.A.C. R9-10-101.
5. "Behavioral Health Technician" or "BHT" means an individual who is not a BHP who provides the following services to a patient to address the patient's behavioral health issue:
    a. With clinical oversight by a BHP, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed as specified in A.R.S. § 32-3274; and
    b. Health-related services.
6. "Child and Family Team" or "CFT" means a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM). A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family Members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship or faith, agents

from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team Members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

7. "Comprehensive Health Plan" or "CHP" means a Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Previous to April 1, 2021, CHP was the Comprehensive Medical and Dental Program (CMDP) (A.R.S. § 8-512).
8. "Court Ordered Evaluation" or "COE" means the evaluation ordered by the court as specified in A.A.C. R9-21-101.
9. "Court Ordered Treatment" or "COT" means the treatment ordered by the court as specified in A.A.C. R9-21-101.
10. "Credentialed Family Support Provider" or "CFSP" – means an individual who is qualified under this policy and has passed an

AHCCCS/DCAIR OIFA approved CFSP Training Program to deliver Family Support Services as a Credentialed Family Support Partner.

11. "Credentialed Family Support Partner Training Program" or "CFSTP" means an AHCCCS/DCAIR OIFA approved credentialing program in compliance with competencies and requirements as specified in this policy.
12. "Credentialed Trainer" means an individual who identifies as having lived experience as specified in this Policy and provides training to individuals seeking employment as a CFSP.
13. "Family Member" means:
    a. for the adult system, an individual who has lived experience as a primary natural support for an adult with emotional, behavioral health and/or Substance Use Disorders (SUD); and
    b. for the children's system, a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health or a SUD.
14. "Family Support Service" means home care training with Family

Member(s) directed toward restoration, enhancement, or maintenance of the family functions to increase the family's ability to effectively interact and care for the individual in the home and community.

15. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record, as specified in A.A.C. R9-28-101.
16. "Integrated System of Care" or "ISOC" means integrated physical and behavioral health care within the AHCCCS health care delivery system focused on ensuring appropriate, adequate, and timely services for all persons across the lifespan, with a primary focus on improving quality of life throughout all system intersections and service interactions that individuals may encounter.
17. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
18. "Office of Human Rights" or "OHR" means established within

AHCCCS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates assist and advocate on behalf of Members determined to have an SMI with Service Planning, Inpatient Discharge Planning, and resolving appeals and grievances.

19. "Office of Individual and Family Affairs Alliance" means a collaborative of all Offices of Individual and Family Affairs (OIFA) in Arizona, including AHCCCS OIFA.
20. "Serious Emotional Disturbance" or "SED" means designation for individuals from birth until the age of 18 who currently meet or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
21. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18

years of age or older.

22. "Substance Use Disorder" or "SUD" means a range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

POLICY

A. PARENT/FAMILY SUPPORT

1. The AdSSs shall support the peer-to-peer relationship of Family Members as a viable component in the delivery of integrated services through provision of quality Family services in support of integrated care in the AHCCCS Children System of Care (CSOC) and Adult System of Care (ASOC).
2. The AdSS shall require:
    a. Credentialing as specified in this policy for reimbursement of Credentialed Family Support Providers (CFSP); and
    b. All Family Support Services provided by a Credentialed Family Support Partner (CFSP) are indicated as credentialed Family Support Services in documentation.

3. The AdSSs shall support the peer-to-peer support relationship available to primary caregivers of Medicaid-eligible children and natural supports of Medicaid-eligible adults who are:
    a. A parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health, or SUD; or
    b. An individual who has lived experience as a primary natural support for an adult with emotional, behavioral health, or SUD.
4. The Division's OIFA, in coordination with AHCCCS/DCAIR OIFA shall establish and maintain ongoing training requirements and credentialing standards for providing Credentialed Family Support Services within the AHCCCS programs, Support Services are defined and not limited to:
    a. Assisting the family to adjust to the individual's needs,
    b. Developing skills to effectively interact, and
    c. Guide the individual's:
        i. Understanding of the causes and treatment of behavioral health challenges;

ii. Understanding and effective utilization of the system; or

iii. Planning for ongoing and future supports for the individual and the family.

B. CREDENTIALED FAMILY SUPPORT PARTNER AND TRAINER QUALIFICATIONS

The AdSS shall require all individuals employed as a CFSP or as a trainer in the children system or adult system to:

a. Meet the definition of a Family Member, and

b. Have lived experience navigating the adult and or child systems of care as:

i. an adult who is the primary supporter of a child, or

ii. the primary supporter of an adult.

C. CREDENTIALED FAMILY SUPPORT PARTNER TRAINING PROGRAM APPROVAL

1. The AdSS shall submit its CFSPTP curriculum, competency exam, and exam-scoring methodology, including an explanation of

accommodations or alternative formats of program materials available to individuals who have special needs, to AHCCCS/DCAIR OIFA at OIFA@azahcccs.gov., and the Division's OIFA at DDDOIFA@azdes.gov.

2. The AdSS shall obtain approval of the curriculum, competency exam, and exam-scoring methodology as specified in this policy from the Division's OIFA and AHCCCS/DCAIR OIFA shall issue feedback.
3. The AdSS shall seek assistance from the Division's identified point of contact within the OIFA who is authorized to assist and advise AdSS for CFSP operators to further develop and enhance their curricula.
    a. The Division's OIFA point of contact provides feedback through the AdSS to C~~P~~FSP operators to further develop and enhance their curricula with a focus on I/DD.
    b. The OIFA Behavioral Health Team in collaboration with other Division Function Areas reviews content of the curriculum ensuring all components and best practices are addressed.

c. In the event that the Division has comments or recommended changes, the OIFA point of contact will provide the information, tracked changes or redlined, to the DDD Health Plan Contract Unit to then disseminate to AdSS and share with CPFSP operators.

4. The AdSSs CFSPTP shall submit updated content to AHCCCS/DCAIR OIFA at OIFA@azahcccs.gov and the Division's OIFA at DDDOIFA@azdes.gov for review and approval before the changed or updated curriculum is to be utilized, if a program makes substantial changes to its curriculum or if there is an addition to required elements.

5. The AdSS shall require approval of the curriculum, competency exam, and exam-scoring methodology based on the elements required in this policy, if a CFSPTP requires regional or culturally specific training exclusive to an AdSS or specific population, the specific training cannot prevent employment or transfer of Family Support credentials based on the additional elements or standards.

6. The AdSS training shall include skills pertinent to the Family

Support of Members with intellectual or developmental disabilities.

7. The AdSS shall not combine a CFSP Training Curriculum with any other training and shall be recognized as a stand-alone program.
8. The AdSS shall ensure the curriculum is maintained and as substantial changes in the ISOC occur, the curriculum is revised.
9. The AdSS shall submit the updated content to AHCCCS/DCAIR OIFA, at OIFA@azahcccs.gov, and the Division's OIFA at DDDOIFA@azdes.gov for review and approval before the changed or updated curriculum is to be utilized.

D. COMPETENCY EXAM

1. The AdSS shall require individuals seeking employment as a CFSP to complete a competency exam as described in section E.3 of this policy, with a minimum score of 80 percent, upon completion of required training to become a CFSP.
2. The AdSS shall require all exams created by the CFSPTPs to include at a minimum, questions related to each of the curriculum core elements as specified in this policy.
3. The AdSS shall require agencies employing CFSP who are

providing Family Support Services to ensure that its employees are trained to work with the populations served.

4. The AdSS shall require upon completion of each class, all AHCCCS registered providers operating a CFSP program to utilize AMPM Policy 964, Attachment B, Credentialed Family Support Provider Graduates, to submit the names of trainees and dates of graduation to the Division, OIFA, via email at dddahcccsdeliverables@azdes.gov.
5. The AdSS shall require AMPM Policy 964, Attachment B to contain no other information apart from what is required.

E. CREDENTIALED FAMILY SUPPORT PARTNER EMPLOYMENT TRAINING CURRICULUM STANDARDS

1. The AdSS shall not duplicate training in the CFSPTP curriculum required of individuals for employment with a licensed agency or Community Service Agency (CSA), training elements in this policy are specific to the CFSP role in the AHCCCS programs and instructional for CFSP interactions.

2. The AdSS shall develop and make available policies and

procedures as well as additional resources for development of curriculum, including AdSS staff contacts for questions or assistance related to training or curriculum.

3. The AdSS shall include in their CFSPTP curriculum the following core elements:
    a. Overview of system history and knowledge of the Arizona behavioral health system that resulted in system transformation:
        i. Arizona Vision (Jason K. lawsuit);
        ii. Jacob's Law;
        iii. Arnold vs. Sarn;
        iv. Adult System of Care (ASOC)- Nine Guiding Principles;
        v. ART;
        vi. Children's System of Care (CSOC)-Twelve Guiding Principles;
        vii. CFT;
        viii. CSOC levels of care
        ix. Medicaid covered services; and

x. Rights of the caregivers and individual rights of Members.

b. Lifecycle Transitions

i. Transition aged youth, and

ii. Guardianship.

a) Types and Alternatives – (e.g., Power of Attorney, Advance Directives), and

b) Process of applying (rules and requirements).

iii. Timelines of transition to adulthood into the ASOC; and

iv. Role changes when bridging the CSOC and ASOC at transition for the individual, family, and CFT.

c. System Partner Overview

i. The Division's three categories of eligibility and eligibility process, covered services, knowledge of the Division's health plans,

ii. CHP program overview, involvement, and collaboration, understanding the CFSP and Member or family role(s) for children in the Department of

Child Safety (DCS) care, education, navigation, support, and advocacy with Members and families involved in DCS care, as described in AMPM 260.

iii. Office of Human Rights and Special Assistance (OHR);

iv. OIFA;

v. Introduction to the Americans with Disabilities Act (ADA);

vi. Introduction to Social Security Income (SSI)/Social Security Disability Insurance (SSDI):

a) Payee services, and

b) Vocational rehabilitation services and available trainings.

vii. Introduction to the criteria and processes for a SED SMI designation;

viii. Introduction to the criteria and processes for COE and COT;

ix. Crisis Services:

a) Crisis planning and prevention;

b) Crisis centers;

c) Crisis Mobile Teams; and

d) Crisis Intervention Training.

d. Advocacy and Empowerment

i. Family and Peer movements and the role of advocacy in systems transformation; and

ii. Building collaborative partnerships and relationships:

a) Engagement, identification, and utilization of strengths; and

b) Utilization and modeling of conflict resolution skills and problem-solving skills.

iii. Understanding of:

a) Individual and family culture, biases, stigma, and systems' cultures; and

b) Trauma informed care approaches.

iv. Natural or Informal supports – identifying, building, and connecting individuals and families, including families of choice, to community and natural supports;

v. Diversity, equity, inclusion, and accessibility in healthcare;

vi. Empowerment:

a) Empowerment of Family Members and other supports to identify their needs, promote self-reliance;

b) Identification of understanding of the stages of change, and unmet needs; and

c) Identification of barriers; family, system, social, emotional, physical, and using effective advocacy skills to overcome barriers.

e. Practice of Support

i. Communication techniques:

a) Individuals first, strengths-based language, using respectful communication, demonstrating care and commitment;

b) Active listening skills, demonstrating empathy, provide empathic responses, differentiation between sympathy and empathy, listening

non-judgmentally; and

c) Use of self-disclosure effectively and sharing one's own story for the benefit of the Member.

ii. Wellness, in terms of understanding:

a) The stages of grief and loss;

b) Self-care and stress management;

c) Compassion fatigue, burnout, and secondary traumatic stress;

d) Resiliency and recovery; and

e) Healthy personal and professional boundaries.

F. SUPERVISION OF CREDENTIALED FAMILY SUPPORT PARTNER

1. The AdSS shall establish the amount of hours and duration of supervision period of CFSP.
2. The AdSS shall require the criteria outlined below:
   a. Providers employing CFSP provide supervision by individuals qualified as BHT or BHP.
      i. Supervision shall be appropriate to the services being delivered and the qualifications of the CFSP as a BHT, BHP, or BHPP.

ii. Supervision shall be documented and inclusive of both clinical and administrative supervision.

b. Individuals providing supervision receive training and guidance to ensure current knowledge of best practices in providing supervision to CFSP.

3. The AdSS shall develop and make available to the providers:

a. Policies, procedures, and resources for establishing supervision requirements of service provision; and

b. Any expectations for providers related to AdSS monitoring or ~~/~~oversight activities.

G. PROCESS FOR SUBMITTING EVIDENCE OF CREDENTIALING

1. The AdSS shall ensure provider agencies:

a. Maintain documentation of required qualifications and credentialing for CFSP; and

b. Make copies of credentials available upon request by the AdSS or the Division.

2. The AdSS shall develop and make available to providers policies and procedures that describe monitoring, auditing, and oversight activities and where records specific to supervision and training

of CFSP are reviewed and maintained.

3. The AdSS shall submit information noting CFSP involvement in service delivery as specified in the AdSS contract with the Division and utilizing AMPM Policy 964 Attachment A, Credentialed Family Support Specialists Involvement in Service Delivery Report.

H. INTERSTATE RECIPROCITY

1. The AdSS shall recognize credentials issued by other states or training programs.
2. The AdSS shall require individuals credentialed in another state to submit their credential to AHCCCS/DCAIR OIFA, via email to AHCCCS OIFA.

I. CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

1. The AdSS shall establish ongoing training requirements of current best practices, for individuals employed as CFSP to obtain continuing education and ongoing learning relevant to family support.
2. The AdSS shall develop and make available to providers the

policies and procedures describing requirements for individuals employed as CFSP to obtain a minimum of eight hours of continuing education and ongoing learning relevant to family support, per year.

3. The AdSS shall require at least one hour of CFSP continuing education to cover ethics and boundaries related to the practice of family support.

SUPPLEMENTAL INFORMATION

The Division's OIFA shall monitor the AdSS' OIFA to ensure that all behavioral health provider sites serving multiple Members shall have regular and ongoing opportunities for Members or Family Members to participate in decision making, quality improvement and enhancement at the provider site.

Signature of Chief Medical Officer: Anthony Dekker (Feb 1, 2024 10:00 MST)
Anthony Dekker, D.O.

965 COMMUNITY SERVICE AGENCIES

REVISION DATE: 5/25/2022, 10/1/2021

EFFECTIVE DATE: September 2, 2020

REFERENCES: A.R.S. §32-33, A.R.S. §32-3251, A.A.C. R4-6-101; A.R.S. §36-501, A.R.S. §32-2061, A.R.S. §32-2091, A.A.C. R9-10-101, A.R.S. §13-705, A.R.S. §13-3212, A.R.S. §13- 3206, A.R.S. §13-3502, A.R.S. §13-3506, A.R.S. §13-3506.01, A.R.S. §13-3512, A.R.S. §13-3555, A.R.S. §13-3558, A.R.S. §36-2903.01(B)(4), A.R.S. §41-6-10, ACOM Policy 103, AMPM Policy 940, AMPM Policy 965 Attachments A - D

PURPOSE

This policy sets forth requirements applicable to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS) for credentialing and monitoring Community Service Agencies (CSAs) and collaboration with other AHCCCS contracted health plans when CSAs participate with more than one AHCCCS contracted health plan.

SCOPE

This policy applies to the AdSS's responsibilities for credentialing and monitoring of CSAs.

DEFINITIONS

Behavioral Health Professional (BHP) must work within their scope of practice and be licensed in the state of Arizona, by the Arizona Board of Behavioral Health Examiners and includes Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Independent Substance Abuse Counselor, Licensed Associate Counselor, Licensed Master Level Social Worker, Licensed Bachelor Level Social Worker, Licensed Associate Marriage Family Therapist, Licensed Associate Substance Abuse Counselor.

A BHP may also be:

A. Psychiatrist

B. Psychologist

C. Physician (MD or DO)

D. Behavior Analyst (cannot provide treatment)

E. Registered Nurse Practitioner (if licensed as an adult psychiatric and mental health nurse)

F. Registered Nurse with:

1. A psychiatric-mental health nursing certification, or

2. One year of experience providing behavioral health services.

Behavioral Health Paraprofessional (BHPP) as specified in A.A.C. R9-10-101, is an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

A. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

B. Are provided under supervision by a behavioral health professional.

Behavioral Health Technician (BHT) as specified in A.A.C. R9-10-101, is an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures and if the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, if the behavioral health services were provided in a setting other than a licensed health care institution, are provided with clinical oversight by a behavioral health professional.

Community Services Agency is a Community Service Agency is an unlicensed provider of non-medical, health related, support services. CSAs provide individualized habilitation (developmental learning), rehabilitation (relearning or readapting), employment, and advocacy services and family supports.

Lead Contractor is an AHCCCS contracted health plan that has the primary responsibility for credentialing, recredentialing and monitoring Community Service Agencies with one or more physical locations that are contracted with health plans.

POLICY

A. OVERVIEW

The AdSS shall have a standardized process for the initial and annual credentialing process of CSAs and for ongoing monitoring of CSAs for programmatic compliance. The AdSS are responsible for ensuring that qualified network community services agencies have the requisite components of the service(s), policies, procedures, and practices to implement the service. CSAs provide services that enhance or supplement behavioral health services that members receive through other licensed agencies. CSAs provide medically necessary rehabilitation and support services to members and their families, including but not limited to the following:

1. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
2. Comprehensive Community Support (Supervised Day)
3. Home Care Training Family (Family Support)
4. Ongoing Support to Maintain Employment
5. Personal Care

6. Psychoeducational Service (Pre-Job Training and Development)

7. Psychosocial Rehabilitation Living Skills Training Services

8. Self-Help/Peer Services (Peer Support)

9. Supervised Behavioral Health Day Treatment and Day Program

10. Transportation

B. INITIAL AND ANNUAL CREDENTIALING PROCESS

The AdSS shall comply with AMPM 965 Community Service Agencies and ensure the following requirements are met in the credentialing of CSAs that serve members of the Division:

1. The applicant shall complete a CSA Application (AMPM Policy 965 Attachment A, Initial Application and Credentialing Amendment Request) in accordance with the application instructions.

2. If the applicant intends to contract with one or more AHCCCS contracted health plan for one or more physical locations, a Lead Contractor will be designated as described in AMPM 965. The Lead Contractor may or may not be an AdSS. If the Lead Contractor is an AdSS, or if the CSA is contracting only with an AdSS, then the AdSS shall follow the procedures set forth in this policy.

    a. The AdSS shall send a notice to the applicant, the Division, AHCCCS/DHCM CSA Compliance Program Specialist, and applicable Contractors, notifying them that the AdSS is the Lead Contractor for credentialing. The notice shall also include documentation submission standards as specified in AMPM Policy 965 Attachment B, Documentation Submission Standards, and deadlines for the initial credentialing desk audit.

C. REVIEW AND APPROVAL PROCESS

After reviewing the application packet, the AdSS shall render a credentialing approval notice or denial decision in writing.

1. The AdSS shall send a CSA credentialing approval notice to the applicant and the Division within 30 calendar days of the AdSS receipt of a timely, compete, and accurate application packet. If the application is denied, the denial decision may include an invitation for the CSA to develop and implement a Corrective Action Plan (CAP) with an outline of information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The AdSS' decision to require a CAP is not subject to appeal.

    a. The AdSS shall send a copy of the CSA credentialing approval notice or denial decision to the Division, AHCCCS/DHCM CSA

Compliance Program Specialist and all other applicable Contractors.

b. Direct service staff members shall meet all Division, AHCCCS and CSA Program Administrator requirements as specified in AMPM Policy 965, Attachment B, such as competency requirements, before providing services.

c. The applicants shall register with AHCCCS/Provider Registration as a CSA provider type before billing for Title XIX/XXI reimbursable services. Applicants may obtain a registration packet by contacting AHCCCS/Provider Registration or via AHCCCS website.

2. Documentation submitted to AHCCCS/Provider Registration shall be consistent with information provided on the application submitted to the AdSS to avoid unnecessary delays in obtaining an AHCCCS provider identification number.

3. Applicants that are establishing more than one CSA locations shall submit a Provider Registration packet for each physical location.

D. Renewal Application Registration and Annual Onsite Monitoring Review

The AdSS shall send a notice, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, and all other applicable contractors of the onsite monitoring review at least 30 calendar days prior to the scheduled visit. The scheduled visit shall occur no less than 60 days from the annual expiration date of the CSA's AHCCCS provider registration status. The notice shall include documentation requirements as specified in AMPM Policy 965, Attachment B, and information on how to prepare for the monitoring visit, including instructions for the day of the scheduled visit.

1. The AdSS shall review all documentation in accordance with the standards as specified in AMPM Policy 965, Attachment B including, but not limited to, any updates to the fire inspection documentation and administrative procedures. Furthermore, the AdSS shall review personnel files of direct service staff members.

2. CSAs shall cooperate with the annual onsite monitoring review and shall:

a. Make available to the AdSS records that include all updated requirements.

b. Make available to the AdSS all requested member records.

c. Participate in the audit entrance and exit conferences with the AdSS employees.

3. After conducting the onsite monitoring review, the AdSS shall render a credentialing approval notice or denial decision in writing, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable AAHCCCS contracted health plans.

4. The denial decision may include an invitation for the CSA to develop and implement a CAP which outlines information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The decision by the AdSS to allow for the development and implementation of a CAP shall include considerations such as allowing the CSA to continue services is in the best interests of the members when the health, safety, and/or welfare of members will not be jeopardized.

    a. The AdSS's decision to require a CAP is not subject to appeal.

    b. The AdSS shall send the CSA credentialing approval notice or denial decision to the CSA and the Division within 30 calendar days of the AdSS onsite audit or a satisfactory completion of a CAP.

    c. The AdSS shall send the CSA approval notice or denial decision to the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable contractors.

E. Credentialing Amendment

1. CSAs shall submit an amendment, at least 30 calendar days before the change. The amendment shall be submitted to the AdSS for CSAs, utilizing AMPM Policy 965, Attachment A and Attachment B, when any of the following information or circumstances occur:

    a. Change in name or address.

    b. Change in the CSA's National Provider Identifier (NPI) and/or Tax Identification Number (TIN).

    c. Change in ownership, governing board, or Chief Executive of the program.

    d. Adding or removing a contractor with which the CSA contracts or intends to contract for the provision of services.

2. CSAs shall report changes to the AHCCCS/Provider Registration Office in addition to the submission of the credentialing amendment request via fax.

3. After conducting a review of the credentialing amendment form and associated documentation, the AdSS shall render an updated credentialing approval notice or denial decision in writing, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Enrollment Unit, and all other applicable contractors.

4. The denial decision may include an invitation for the CSA to develop and implement a CAP along with an outline of information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The decision by the AdSS to allow for the development and implementation of a CAP shall include considerations such as allowing the agency to continue services is in the best

interests of the members when the health, safety, and/or welfare of members will not be jeopardized.

a. The AdSS's decision to require a CAP is not subject to appeal.

b. The AdSS contractor shall send the CSA credentialing approval notice or denial decision to the CSA and the Division within 30 calendar days of the receipt of the credentialing amendment request.

c. The AdSS shall send the CSA approval notice or denial decision to the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable contractors.

F. Denials, Suspension, Or Revocation of a CSA AHCCCS Registration

1. If the AdSS receives notification from AHCCCS that a CSA's AHCCCS registration is denied, suspended, or revoked, it shall deny, suspend, or revoke the CSAs participation in its network.

2. The AdSS are responsible for sending the outcome of credentialing renewals, amendments, and onsite monitoring reviews that result in a denial, suspension, or revocation, to the Division, AHCCCS/Provider Registration. AHCCCS/Provider Registration is responsible for rendering the final decision about the CSAs initial or continued status as an AHCCCS registered provider.

G. CSA VOLUNTARY WITHDRAWAL OR SUSPENSION OF A CSA REGISTRATION

1. If a CSA no longer intends to deliver services as a CSA to any AdSS contractor, the CSA shall notify the AdSS that the CSA is contracted with to provide services, the Division, the AHCCCS/DHCMCSA Compliance Program Specialist, and AHCCCS/Provider Registration in writing at least 30 calendar days in advance of the last date the service will be offered.

2. If an AdSS determines that a rehabilitation and/or support service will no longer be provided by the CSA, the AdSS shall notify all AHCCCS health plans contracted with the CSA to provide services and the Division along with AHCCCS/DHCM CSA Compliance Program Specialist in writing at least 30 calendar days in advance of the contract termination date.

3. If a CSA no longer holds a contract with any AdSS contractor but intends or is in the process of contracting with another health plan the CSA shall notify AHCCCS/Provider Registration in writing at least 30 calendar days in advance of the last date the service will be offered. AHCCCS/Provider Registration, at its sole discretion, may choose to allow the CSA to remain an AHCCCS Registered Provider, but suspend the CSAs' ability to bill for services. The AdSS shall adhere to reporting and notification requirements established in contract to ensure that network changes are communicated, and transition plans are implemented for the continuation of services to members. At the point in time when the CSA is contracted with at least one AHCCCS health plan contractor, the CSA shall initiate the initial application process outlined in this policy.

4. In all circumstances noted above, the AdSS and CSAs shall coordinate the transition of members to ensure continuity of care.

H. AHCCCS CONTRACTED HEALTH PLANS COLLABORATIVE FOR CREDENTIALING AND ONSITE MONITORING REVIEWS

1. The AdSS shall coordinate CSA credentialing and onsite monitoring reviews when the CSA is contracted with more than one AHCCCS contracted health plan as described in this section.

2. The AdSS shall participate with other AHCCCS contracted health plans in a collaborative process to perform initial and annual credentialing and annual onsite monitoring of CSAs, which shall include but not be limited to the following:

   a. Designate and maintain a listing of points of contact at each contractor and providing the Division and AHCCCS/DHCMCSA Compliance Program Specialist with updated copies of the list as revisions are made.

   b. Establish criteria for determining the Lead Contractor for each CSA.

   c. Develop standard forms including communication and approval notices, audit tools, and CAPs to be utilized by the AdSS or applicable Lead Contractor. All standard forms shall be approved by AHCCCS before use, including initial drafts and proposed revisions. Develop processes and standards for member record reviews for the onsite monitoring review.

   d. Develop processes for secondary reviews by another AHCCCS contracted health plan should a CSA fail to receive an approved credentialing notice from the Lead Contractor, or upon request by a CSA or an AHCCCS contracted health plan for any reason as deemed necessary.

Signature of Chief Medical Officer: Anthony Dekker (May 17, 2022 20:38 PDT)

Anthony Dekker, D.O.

970 PERFORMANCE MEASURES

REVISION DATES: 9/6/23, 3/09/22, 10/28/20

EFFECTIVE DATE: October 1, 2019

REFERENCE: 42 CFR Part 438

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division or DDD) Administrative Services Subcontractors (AdSS) and establishes requirements to implement, Evaluate, monitor, and report on performance measures and associated improvement activities to the Division.

DEFINITIONS

1. "Benchmark" means the process of comparing a practice's performance with an external standard to motivate engagement in quality improvement efforts and understand where performance falls in comparison to others. Benchmarks may be generated from similar organizations, quality collaboratives, or authoritative bodies.
2. "Evaluate" means the process used to examine and determine the level of quality or the progress toward improvement of quality or performance related to service delivery systems.

3. "Health Information System" means a primary data system that collects, analyzes, integrates, and reports data to achieve the Objectives outlined under 42 CFR 438, and data systems composed of the resources, technology, and methods required to optimize the acquisition, storage, retrieval, analysis, and use of data.
4. "Inter-Rater Reliability" means the process of ensuring that multiple observers are able to consistently define a situation or occurrence in the same manner, which is then recorded.
5. "Long-Term Services and Supports" means services and supports provided to Members who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice as specified in 42 CFR 438.2.
6. "Measurable" means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive Outcome.
7. "Member" means the same as "client" as defined in A.R.S. § 36-551.
8. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive Outcome.

9. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities and documenting results via desktop or onsite review.
10. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
11. "Official Rates" means Performance Measure results calculated by the Division that have been validated by the AHCCCS External Quality Review Organization for the calendar year.
12. "Outcome" means a change in patient health, functional status, satisfaction, or goal achievement that results from health care or supportive services [42 CFR 438.320].
13. "Performance Improvement" means the continuous study and improvement of processes with the intent to better services or Outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent or systemic problems or barriers to improvement.
14. "Performance Measure Performance Standards" means the minimal expected level of performance. The official performance measure rates are based upon the National Committee for Quality Assurance,

HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services Medicaid Median (for selected Core Set-Only Measures) as identified by the Arizona Health Care Cost Containment System (AHCCCS), as well as the line of business aggregate rates, as applicable.

15. "Plan-Do-Study-Act Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period the approach is known as Rapid Cycle Improvement. The Plan-Do-Study-Act Cycle consists of the following steps:
    a. Plan: Plan the changes or interventions, including a plan for collecting data. State the Objectives of the interventions
    b. Do: Try out the interventions and document any problems or unexpected results.
    c. Study: Analyze the data and study the results. Compare the data to predictions and summarize what was learned.
    d. Act: Refine the changes or interventions based on what was learned, and prepare a plan for retesting the interventions.

e. Repeat: Continue the cycle as new data becomes available until improvement is achieved.

14. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.

15. "Triple Aim" means a framework for optimizing health system performance consisting of the following three components:

a. Improve the experience and Outcomes of care,

b. Improve the health of populations, and

c. Reduce the per capita costs of healthcare.

POLICY

A. PERFORMANCE MEASURES

1. The AdSS shall collect, monitor, and Evaluate data relevant to Division specific performance measures for required performance metrics in the areas of:

a. Quality,

b. Timeliness,

c. Utilization,

d. Efficiency,

e. Member Satisfaction,

f. Targeted Investment, and

g. Performance Improvement.

2. The AdSS shall use ongoing collection, Monitoring, and evaluation of performance metric data to develop specific Measurable goals and Objectives aimed at enhancing the Quality Management/Performance Improvement (QM/PI) Program.

3. The AdSS shall report performance metric data to the Division for the following:

a. Quality Management/Quality of Care (QOC);

b. Medical Management;

c. Maternal and Child Health;

d. Network Adequacy; and

e. Waiver/Program Evaluation.

4. The AdSS' QM/IP program shall use standardized performance

measures that focus on the following clinical and non-clinical areas reflective of the Centers for Medicare and Medicaid Services (CMS) Core Set domains of care:

a. Primary Care Access and Preventive Care;

b. Maternal and Perinatal Health;

c. Care of Acute and Chronic Conditions;

d. Behavioral Health Care;

e. Dental and Oral Health Services;

f. Experience of Care; and

g. Long-Term Services and Supports (LTSS) as specified in the AdSS' contract.

5. The AdSS shall measure and report on performance measures in accordance with CMS and AHCCCS requirements.

6. The AdSS shall comply with Division and AHCCCS QM/PI Program requirements to enhance performance for all required performance measures.

7. The AdSS shall compare the performance measure rates with national Benchmarks specified in the AdSS' contract effective during that measurement period.

8. The Division shall Evaluate the AdSS' compliance with performance measure requirements at least quarterly.

9. The AdSS shall include LTSS specific performance measures.

B. PERFORMANCE MEASURE REQUIREMENTS

1. The AdSS shall:

   a. Adhere to the requirements specified within the AdSS' contract related to performance measure requirements.

   b. Utilize the results of the Official Rates in evaluating the QM/PI Program.

   c. Show Statistically Significant improvement from year to year, which is sustained over time, to meet the Performance Measure Performance Standards (PMPS).

      i. Sustained improvement is demonstrated when it

establishes how the Statistically Significant improvement can be reasonably attributable to interventions undertaken by the AdSS, and

ii. Maintains or increases the improvements in performance for at least one year after the Performance Improvement is first achieved.

d. Measure and report performance measures, and meet any associated standards identified by the Division, AHCCCS or CMS.

e. Achieve the PMPS outlined in the AdSS' contract for each measure using the Official Rates.

f. Demonstrate sustained and improved efforts throughout the performance cycle when the PMPS have been met.

2. The AdSS shall develop an evidence-based Corrective Action Plan (CAP) for each performance measure not meeting the PMPS to improve performance to at least the minimum standards required by the Division and align with the requirements of AHCCCS Medical Policy 920, Attachment B.

3. The AdSS shall ensure that each CAP includes a list of activities or strategies to allocate increased administrative resources to improve rates for a specific measure or service area.
4. The AdSS shall submit the CAP to the Division for review and approval prior to implementation.
5. The AdSS shall show Statistically Significant and sustained improvement towards meeting the PMPS.
6. If requested by the Division, the AdSS shall develop CAPs for measures that are below the PMPS or that show a Statistically Significant decrease in rates even if it meets or exceeds the PMPS.
7. The AdSS shall report any discrepancies identified in encounters received by the Division, and the status of such discrepancies, to the Division's Quality Improvement Manager.

C. PERFORMANCE MEASURE ANALYSIS

1. The AdSS shall conduct data analysis related to the performance measure rates to improve the quality of the care provided to Members, identify opportunities for improvement, and implement targeted interventions.

2. The AdSS shall Evaluate performance rates to improve the quality of care provided to members, identify opportunities for improvement, and implement targeted interventions.

3. The AdSS shall evaluate performance for aggregate and subpopulations, inclusive of any focus areas identified by the Division or AHCCCS, including the analysis of performance to identify health disparities and related opportunities for improvement.

4. The AdSS shall utilize proven quality improvement tools when conducting root-cause analysis and problem-solving activities.

5. The AdSS shall identify and implement targeted interventions to address any noted disparities identified as part of the AdSS' data analysis efforts.

6. The AdSS shall conduct Plan-Do-Study-Act (PDSA) Cycles to Evaluate the effectiveness of interventions, revise interventions as needed, and conduct repeat PDSA Cycles until improvement is achieved.

D. INTER-RATER RELIABILITY

1. When AdSS are directed to collect data to measure performance, and if requested by the Division, the AdSS shall submit specific documentation to verify that indicator criteria were met in accordance with Division requirements.

2. The AdSS shall assign qualified personnel to collect data.

3. The AdSS shall ensure Inter-Rater Reliability if more than one person is collecting and entering data.

4. The AdSS shall ensure that data collected from multiple individuals is consistent and comparable through an implemented Inter-Rater Reliability process, as specified in AdSS Medical Policy 960, and documented as follows:

    a. A detailed description of the Methodology for conducting Inter-Rater Reliability and required training;

    b. Oversight and validation of data collection;

    c. Minimum testing score required to continue participation in the data collection and reporting process;

d. A mechanism for evaluating individual accuracy scores; and

e. Actions taken if an individual does not meet the established accuracy score.

5. The AdSS shall monitor and track the Inter-Rater Reliability accuracy scores and associated follow-up activities.

6. Upon request from the Division, the AdSS shall provide evidence of implementation of the Inter-Rater Reliability process and associated Monitoring.

E. PERFORMANCE METRIC AND MEASURE REPORTING

1. The AdSS shall report the QM/PI Program performance to the Division using the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template.

2. The AdSS shall analyze and report the performance separately by DDD line of business.

3. The AdSS shall calculate and report combined rates/percentages for the DDD population; however, the AdSS shall have the ability to calculate and report numerators, denominators, and

rate/percentage for Medicaid, which is provided in accordance with AHCCCS or Division request or instructions.

3. The AdSS shall monitor KidsCare performance metrics and measures to ensure compliance with contractual standards.

4. The AdSS shall report performance measure performance to the Division in accordance with the AdSS' contract.

Signature of the Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:28 PDT)
Anthony Dekker, D.O.

980 PERFORMANCE IMPROVEMENT PROJECTS

REVISION DATE: 6/7/2023, 9/15/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.330, Section F3, Contractor Chart of Deliverables

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and delineates the purpose, design, implementation, and reporting of Division or AHCCCS-mandated and AdSS self-selected Performance Improvement Projects (PIPs).

DEFINITIONS

1. "Baseline Data'' means data collected at the beginning of a PIP that is used as a starting point for measurement and the basis for comparison with subsequent remeasurement(s) in demonstrating significant and sustained improvement.
2. "Benchmark" means the process of comparing a practice's performance with an external standard to motivate engagement in quality improvement efforts and understand where

performance falls in comparison to others. Benchmarks may be generated from similar organizations, quality collaboratives, and authoritative bodies.

3. “Grievance” means a member’s expression of dissatisfaction with any matter, other than an adverse benefit determination.
4. “Methodology” means the planned documented process, steps, activities, or actions taken to achieve a goal or objective, or to progress towards a positive outcome.
5. “Monitoring” means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
6. “Objective” means a measurable step, generally one of a series of progressive steps, to achieve a goal.
7. “Outcomes” means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].
8. “Performance Improvement Project (PIP)” means a planned process of data gathering, evaluation and analysis to determine

interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

9. "Plan Do Study Act (PDSA) Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period, i.e., over days, weeks, or months, the approach is known as Rapid Cycle Improvement.
10. "Plan Do Study Act (PDSA) Method" means a four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA Cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.
11. "Quality" as specified in 42 CFR 438.320, pertains to external

quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its members through:

a. Its structural and operational characteristics.

b. The provision of services that are consistent with current professional, evidence-based knowledge.

c. Interventions for performance.

12. "Statistically Significant" means a judgment of whether a result occurs because of change. When a result is statistically significant, it means that it is unlikely that the result occurs because of chance or random fluctuation. There is a cutoff for determining statistical significance. This cutoff is the significance level. If the probability of a result (the significance value) is less than the cutoff (the significance level), the result is judged to be statistically significant.

13. "Validation" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data

collection and analysis.

POLICY

A. PERFORMANCE IMPROVEMENT PROJECT (PIP) REQUIREMENTS

1. The AdSS shall participate in PIPs selected by the Division and AHCCCS.

2. The AdSS shall select and design, with Division approval, additional PIPs specific to needs identified through internal monitoring of trends and data.

3. The AdSS shall consider all populations and services covered when developing quality assessments and PIPs.

4. The AdSS shall participate in performance measures and PIPs that are mandated by the Centers for Medicare and Medicaid Services (CMS).

B. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) DESIGN

1. The AdSS shall conduct PIPs, including any PIPs required by CMS, that focus on either clinical or non-clinical areas.

    a. Clinical focus topics may include:

i. Primary, secondary, and/or tertiary prevention of acute conditions;
ii. Primary, secondary, and/or tertiary prevention of chronic conditions;
iii. Primary, secondary, and/or tertiary prevention of behavioral health conditions;
iv. Care of acute conditions;
v. Care of chronic conditions;
vi. Care of behavioral health conditions; and
vii. Continuity and coordination of care.

b. Non-clinical focus topics may include:
i. Availability, accessibility, and adequacy of Contractor's service delivery system;
ii. Cultural competency of services;
iii. Interpersonal aspects of care (e.g., quality of provider/member encounters); and
iv. Appeals, grievances, and other complaints.

2. The AdSS shall identify and implement clinical and non-clinical focused PIPs that are meaningful to the population(s) served and based on self-identified opportunities for improvement. This will be supported by:

a. Root cause analyses,

b. External and internal data,

c. Surveillance of trends, or

d. Other information available to the AdSS.

3. The AdSS shall adhere to the protocol in 42 CFR 438.330 when developing PIPs.

4. The AdSS shall also adhere to and align with the protocol specified in AMPM Policy 980 – Attachment A, Protocol for Conducting Performance Improvement Projects, when selecting, designing, developing, and implementing self-selected PIPs.

5. The AdSS shall use the PDSA Method to test changes (interventions) quickly and refine them, as necessary.

6. The AdSS shall utilize several PDSA Cycles within the PIP lifespan.

7. The AdSS shall implement the PDSA Cycles in as short a time frame as practical, based on the PIP topic.

8. The AdSS shall include the following steps in the PDSA Cycle:

a. Plan the change(s) or intervention(s), including a plan

for collecting data. State the objective(s) of the intervention(s).

b. Try out the intervention(s) and document any problems or unexpected results.

c. Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

d. Refine the change(s) or intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).

e. Continue the cycle as new data becomes available until improvement is achieved.

9. The AdSS shall include all PDSA Cycles conducted as part of the PIP within the AdSS' PIP Report submissions.

C. PERFORMANCE IMPROVEMENT PROJECT (PIP) TIMEFRAMES

1. AHCCCS-Mandated PIPs

a. The AdSS shall initiate mandated PIPs on the date established by the Division or AHCCCS.

b. The AdSS shall collect and analyze data at the beginning of the PIP.

c. During the Intervention year, the AdSS shall implement innovative and/or evidence-based interventions to improve performance.

d. The AdSS shall base this on an evaluation of barriers and root cause analysis.

e. The AdSS' interventions shall consider any unique factors such as:

    i. The AdSS' membership,

    ii. The provider network, and

    iii. The geographic area(s) served.

f. The AdSS shall utilize annual measurements to evaluate their performance; however, AHCCCS may require interim measurements, depending on the resources required to collect and analyze data.

g. In cases where AHCCCS elects to implement Rapid Cycle PIPs, the AdSS shall report at the intervals indicated within the associated PIP methodologies.

h. The AdSS' participation in the PIP shall continue until they demonstrate significant and sustained improvement, as outlined in Section E, or as directed by AHCCCS.

2. AdSS Self-Selected PIPs

a. Self-selected PIP timelines may vary with the AdSS encouraged to implement Rapid Cycle PIPs where applicable and appropriate, and

b. The AdSS' participation in the PIP shall continue until the AdSS demonstrates significant and sustained improvement, as outlined in Section E, or as approved by AHCCCS when significant and sustained improvement has not been demonstrated.

D. DATA COLLECTION METHODOLOGY

1. The AdSS shall align their data collection methodology, including project indicators, procedures, and timelines, with the guidance and direction provided for all AHCCCS-mandated PIPs.
2. The AdSS shall evaluate their performance on the selected PIP indicators based on systematic, ongoing collection and analysis of accurate, valid, and reliable data, as collected and reported by AHCCCS or as validated by the AHCCCS External Quality Review Organization (EQRO).
3. The AdSS shall ensure collected data are accurate, valid, and reliable through internal processes for self-selected PIPs that are not based on standardized performance measures.

E. INTER-RATER RELIABILITY

1. For PIPs that are not based on standardized performance measures as well as performance measures not included within AHCCCS Contract, the AdSS shall:
   a. Submit specific documentation to verify that indicator criteria were met in accordance with AHCCCS instruction,
   b. Have qualified personnel collect data,

c. Ensure inter-rater reliability if more than one person is collecting and entering data.

2. The AdSS shall ensure that data collected from multiple parties/individuals for PIP indicators is consistent and comparable through an implemented inter-rater reliability process.

3. The AdSS' documented inter-rater reliability process shall include:

   a. A detailed description of the AdSS' methodology for conducting inter-rater reliability including:

      i. Initial training (and retraining, if applicable);

      ii. Oversight;

      iii. Validation of data collection; and

      iv. Other activities deemed applicable.

   b. The required minimum score that each individual shall obtain in order to continue participation in the data collection and reporting process;

c. A mechanism for evaluating individual accuracy scores (and any subsequent accuracy scores, if applicable); and

d. The actions taken should an individual not meet the established accuracy score.

4. The AdSS shall monitor and track the inter-rater reliability accuracy scores and associated follow up activities.

5. The AdSS shall provide evidence of implementation of the inter-rater reliability process as well as the associated monitoring upon AHCCCS request.

F. MEASUREMENT OF SIGNIFICANT DEMONSTRABLE IMPROVEMENT

1. The AdSS shall implement interventions to achieve and sustain statistically significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator.

2. The AdSS shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured.

3. The AdSS shall show evidence of improvement in repeated measurements of the PIP indicators specified for each active PIP.

4. The AdSS shall demonstrate significant improvement when the improvement in the PIP indicator rate(s) from one measurement year to the next measurement year is statistically significant.
5. The AdSS shall demonstrate sustained improvement when it:
    a. Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason); and
    b. Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance is first achieved.

G. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) REPORTING REQUIREMENTS

1. The AdSS shall refer to the AHCCCS Quality Management/Performance Improvement (QM/PI) Reporting Templates & Checklists section of the AHCCCS website to locate the associated tools the AdSS shall utilize, as outlined in this

section, when preparing and submitting the required deliverables.

2. The AdSS shall include baseline and annual remeasurements, inclusive of rates and results used as the basis for analysis, both quantitative and qualitative, and the selection/modification of interventions, within the AdSS's PIP report submissions.
3. The AdSS shall submit reports that contain population/line of business-specific data, reflective of the AdSS' performance during the current and previous reporting periods in alignment with the associated PIP timeline.
4. The AdSS shall ensure the inclusion of subpopulation data and disparity analyses within its reporting, with the identification of targeted interventions to be implemented specific to findings, in alignment with the AHCCCS PIP Report Template and Attachment instructions.
5. AHCCCS-mandated PIPs
    a. The AdSS shall submit PIP reports for all AHCCCS-mandated PIPs, as specified in Contract.

b. The AdSS shall utilize the AHCCCS PIP Report Template and Attachment that is applicable to the population/line of business being reported.

c. The AdSS shall report rates and results, reflective of combined Title XIX and Title XXI populations, as applicable to the population/line of business.

d. The AdSS shall indicate if the interventions are applicable to Title XIX, Title XXI, or both populations.

e. The AdSS shall submit a final PIP report, as specified in Contract, following the year in which significant and sustained improvement is demonstrated.

f. The AdSS shall evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official PIP indicator rates, as specified in Contract and the associated AHCCCS PIP Methodology.

g. The AdSS shall utilize its Remeasurement Year two (or subsequent year, if required) PIP report to serve as their final PIP report submission contingent upon the following:

i. The AdSS has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and

ii. The sections required as part of the final PIP report have been completed.

h. The AdSS shall keep AHCCCS-mandated PIPs open until formal notification of approval for PIP closure from AHCCCS is received.

i. The AdSS shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

6. AdSS self-selected PIPs

a. The AdSS shall submit a Contractor Self-Selected PIP Initiation Notification, as specified in Contract.

b. The AdSS shall submit PIP reports for self-selected PIPs, active during the previous calendar year, as specified in Contract.

c. The AdSS shall utilize the AHCCCS PIP Report Template and Attachment, specific to population/line of business.

d. The AdSS shall indicate if measurements/rates and results are reflective of combined Title XIX and Title XXI populations, as applicable to population/line of business.

e. The AdSS shall indicate if the interventions are applicable to the Title XIX, Title XXI, or both populations.

f. The AdSS shall submit a final self-selected PIP report, as specified in Contract, following the year in which significant and sustained improvement is demonstrated.

g. The AdSS shall evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official performance measure rates, as specified in Contract.

h. The AdSS shall evaluate significant and sustained improvement based on the AdSS' internally collected and validated data for self-selected PIPs that are not based on standardized performance measures and calendar year performance.

i. The AdSS shall utilize its Remeasurement Year two (or subsequent year, if required) PIP report to serve as their final PIP report submission contingent upon the following:

   i. The AdSS has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and

   ii. The sections required as part of the final PIP report have been completed.

j. The AdSS shall keep AdSS self-selected PIPs open until the AdSS has met criteria related to significant and sustained improvement.

k. The AdSS shall submit a PIP Closure Request for each PIP they are requesting to close for AHCCCS' review and approval.

l. The AdSS shall indicate the rationale for closing a PIP in cases where the AdSS has not met criteria related to significant and sustained improvement to support PIP closure.

m. The AdSS shall close the PIP when formal notification of approval for PIP closure has been received from AHCCCS.

n. The AdSS shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

Signature of Chief Medical Officer: Anthony Dekker (Jun 2, 2023 15:35 PDT)
Anthony Dekker, D.O.

1001 SECOND LEVEL REVIEW

EFFECTIVE DATE: May 3, 2023
REFERENCES:

PURPOSE

The purpose of this policy is to outline the requirements related to the Second Level Review process for Arizona Long Term Care System (ALTCS) eligible members. It applies to the Division of Developmental Disabilities Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Behavioral Health Residential Facility" or "BHRF" means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
    a. Limits the individual's ability to be independent, or
    b. Causes the individual to require treatment to maintain or enhance independence.
2. "Health Care Professional" means a physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant,

speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

3. "Practitioner" refers to a Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.
4. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the member's medical record to ensure Division members are receiving medically appropriate and high quality care.

POLICY

A. AUTHORIZATION OF SERVICES

1. The AdSS shall have written policies and procedures for processing requests for initial and continuing authorizations of services.
2. The AdSS shall ensure timely notification of requests for services that are provided by the Division.
3. The AdSS shall ensure that any decision to deny a service authorization request or to authorize a service amount shall be made by a Health Care Professional who has appropriate clinical expertise in treating the member's condition or disease.
4. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
    a. Behavioral Health Residential Facility (denials only);
    b. Enclosed or partially enclosed beds;
    c. Hysterectomy;
    d. Sterilization;
    e. Termination of pregnancy; or
    f. Transplants (denials only).

5. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant related medications prior to denying services.
6. The AdSS shall submit a request to the Division for prior authorization with clinical documentation that supports medical necessity for the required service and includes the following:
    a. Medical records related to the request;
    b. Prescription signed by a Practitioner; and
    c. If the request is for an enclosed bed, the Healthcare Common Procedure Coding System (HCPCS) code of the bed being requested and a picture of the bed if using miscellaneous HCPCS E1399.
7. The AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven business days, for review and response for standard service authorization requests, and two business days for expedited service authorization requests. Expedited requests must be clearly labeled as expedited.

7. The AdSS may request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2023 11:33 PDT)
Anthony Dekker, D.O.

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

REVISION DATES: 10/28/2020

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2907, A.R.S. § 36-2907(B), 9 A. A.C. 34, A.A.C. R9-22-201 et seq., 42 CFR 438.210(b)(3), 42 CFR 438.406(a)(2)(i), Section F3, Contractor Chart of Deliverables, ACOM Policy 414, ACOM 438 AMPM Policy 1020

Purpose

The Division of Developmental Disabilities (Division) contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility of implementation of the Medical Management administrative requirements. The Division oversees the AdSS and ensures implementation and compliance of all requirements in this policy.

Definitions

Plan, Do, Study Act (PDSA) Method - A four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

Medical Management Annual Plan

A. The AdSS shall develop a written Medical Management Plan that describes the methodology used to meet or exceed the standards and requirements of its contract with the Division, and AdSS Chapter 1000.

B. The AdSS shall submit the Medical Management Plan, and any subsequent modifications, to the Division for review and approval prior to implementation. Refer AMPM Policy 1020.

C. At a minimum, the Medical Management Plan shall describe, in detail, the Medical Management program and how program activities assure appropriate management of medical care service delivery for enrolled members. Medical Management Plan components shall include:

1. A description of the AdSS' administrative structure for oversight of its Medical Management program as required by this policy, including the role and responsibilities of:

    a. The governing or policy-making body,

    b. The Medical Management Committee,

    c. The AdSS Executive Management, and

    d. Medical Management program staff.

2. An organizational chart that delineates the reporting channels for Medical Management activities and the relationship to the AdSS Chief Medical Officer

and Executive Management.

3. Documentation that the governing or policy-making body has reviewed and approved the Medical Management Plan.

4. Documentation that appropriately qualified, trained, and experienced personnel are employed to effectively carry out Medical Management program functions and meet qualification required by this policy.

5. The AdSS' specific Medical Management goals and measurable objectives as required by AMPM Policy 1020.

6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:

    a. Medical Management Utilization Data Analysis and Data Management

    b. Concurrent Review

    c. Discharge Planning

    d. Prior Authorization

    e. Inter-Rater Reliability

    f. Retrospective Review

    g. Clinical Practice Guidelines

    h. New Medical Technologies and New Uses of Existing Technologies

    i. Case Management/Care Coordination

    j. Disease/Chronic Care Management

    k. Drug Utilization Review

7. The AdSS' method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AMPM Policy 1020.

8. A description of how delegated activities are integrated into the overall Medical Management program and the methodologies for oversight and accountability of all delegated functions, as required by this policy.

9. Documentation of input into the medical coverage policies from the AdSS or affiliated providers and members.

10. A summary of the changes made to the AdSS' list of services requiring prior authorization and the rationale for those changes.

Medical Management Work Plan

The AdSS are responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the Medical Management Program requirements outlined in AMPM Policy1020. The work plan shall:

A. Be submitted in an acceptable format on the template adopted by the Division and provided by AHCCCS.

B. Support the Medical Management Plan goals and objectives.

C. Include goals that are quantifiable and reasonably attainable.

D. Include specific actions for improvement.

E. Incorporate a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AdSS Medical Policy 970 for details related to PDSA methodologies.

Medical Management Evaluation

A. An annual narrative evaluation of the effectiveness of the previous year's Medical Management strategies and activities shall be submitted to the Division after being reviewed and approved by the AdSS' governing or policy-making body. The narrative summary of the previous year's work plan shall include but is not limited to:

   1. A summary of the Medical Management activities performed throughout the year with:

      a. Title/name of each activity,

      b. Desired goal and/or objective(s) related to each activity,

      c. Staff positions involved in the activities,

      d. Trends identified and the resulting actions implemented for improvement,

      e. Rationale for actions taken or changes made, and

      f. Statement describing whether the goals/objectives were met.

   2. Review, evaluation, and approval by the Medical Management Committee of any changes to the Medical Management Plan.

   3. Necessary follow-up with targeted timelines for revisions made to the Medical Management Plan.

B. The Medical Management Plan and Medical Management Evaluation may be combined or written separately, as long as required components are addressed and easily located.

C. Refer to Section F3, Contractor Chart of Deliverables for reporting requirements and timelines.

Medical Management Administrative Oversight

A. The AdSS Medical Management program shall be administered through a clear and appropriate administrative structure. The governing or policy-making body shall oversee and be accountable for the Medical Management program. AdSS shall ensure ongoing communication and collaboration between the Medical Management program and the other functional areas of the AdSS' organization (e.g., quality management, member and provider services).

B. The AdSS shall have an identifiable and structured Medical Management Committee that is responsible for Medical Management functions and responsibilities, or if the Medical Management Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that Medical Management issues and topics are presented, discussed, and acted upon.

C. At a minimum, the membership shall include:

1. The Chief Medical Officer or designated Medical Director, as the chairperson of the Medical Management Committee;

2. The Medical Management Manager;

3. Representation from the functional areas within the AdSS' organization;

4. AdSS staff with experience with developmental disabilities, behavior health, and medically fragile physical health conditions; and

5. Representation of contracted or affiliated providers.

D. The Chief Medical Officer or designated Medical Director, as chairperson for the Medical Management Committee, or his/her designee, is responsible for the implementation of the Medical Management Plan and shall have substantial involvement in the assessment and improvement of Medical Management activities.

E. The Medical Management Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or Medical Management Committee sign-in sheets with requirements noted).

F. The frequency of Medical Management Committee meetings shall be sufficient to demonstrate that the Medical Management Committee monitors all findings and required actions. At a minimum, the Medical Management Committee shall meet quarterly.

G. Medical Management Committee meeting minutes shall include the data reported to the Medical Management Committee, and analysis and recommendations made by the Medical Management Committee. Data, including utilization data, may be attached to the Medical Management Committee meeting minutes as separate

documents if the documents are noted in the Medical Management Committee meeting minutes. Recommendations made by the Medical Management Committee shall be discussed at subsequent Medical Management Committee meetings. The Medical Management Committee shall review the Medical Management program objectives and policies annually and updates them as necessary to ensure:

1. The Medical Management responsibilities are clearly documented for each Medical Management function/activity;

2. The AdSS and their providers are informed of the most current Medical Management requirements, policies, and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community;

3. The AdSS and their providers are informed of information related to their performance (e.g., provider profiling data); and

4. The Medical Management policies and procedures, and any subsequent modifications to them, are available upon request by the Division.

H. The Medical Management program shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in AdSS Chapter 1000.

I. Staff qualifications for education, experience, and training shall be developed for each Medical Management position.

J. The grievance process shall be part of the new hire and annual staff training, which includes:

1. What constitutes a grievance,

2. How to report a grievance, and

3. The role of the AdSS' Quality Management staff in grievance resolution.

K. A current organizational chart is maintained to show reporting channels and responsibilities for the Medical Management program.

L. The AdSS shall maintain records that document Medical Management activities, and it shall make the information available to the Division upon request. The required documentation includes, but is not limited to:

1. Policies and procedures;

2. Reports;

3. Practice guidelines;

4. Standards for authorization decisions;

5. Documentation resulting from clinical reviews (e.g. notes related to

concurrent review, retrospective review, and prior authorization);

6. Meeting minutes including analyses, conclusions, and actions required with completion dates;

7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the Medical Management program such as inter-rater reliability; and

8. Other information and data deemed appropriate to support changes made to the scope of the Medical Management Plan.

M. The AdSS shall have written policies and procedures pertaining to:

1. Verification that information/data received from providers is accurate, timely, and complete;

2. Review of reported data for accuracy, completeness, logic, and consistency, (review and evaluation processes used shall be clearly documented);

3. Security and confidentiality of all member and provider information protected by Federal and State law;

4. Informing of appropriate parties of the Medical Management requirements and updates, utilization data reports, and profiling results;

5. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services;

6. Quarterly evaluations and trending of internal appeal overturn rates;

7. Quarterly evaluations of the timeliness of service request decisions; and

8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

N. The AdSS shall have processes that ensure:

1. Per 42 CFR 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, render decisions to:

a. Deny an authorization request based on medical necessity;

b. Authorize a request in an amount, duration, or scope that is less than requested; and

c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in this policy.

2. Per 42 CFR 438.406(a)(2)(i) qualified health care professionals, with appropriate clinical expertise in treating the members' condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:

    a. Appeals involving denials based on medical necessity,

    b. Grievances regarding denial of expedited resolution of an appeal, and

    c. Grievances and appeals involving clinical issues.

3. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice:

    a. Physician

    b. Podiatrist

    c. Optometrist

    d. Chiropractor

    e. Psychologist

    f. Dentist

    g. Physician assistant

    h. Physical or occupational therapist

    i. Speech-language pathologist

    j. Audiologist

    k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist. certified registered nurse anesthetist and certified nurse midwife)

    l. Licensed social worker

    m. Registered respiratory therapist

    n. Licensed marriage and family therapist

    o. Licensed professional counselor.

4. Decision-making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

5. ALTCS Case Management staff shall have appropriate clinical expertise to render decisions for non-skilled Home and Community Based Services (e.g.

personal care, homemaker, non-nursing respite care).

6. Consistent application of standards and clinical criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action shall be developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%.

7. Prompt notifications to the requesting provider and the member/guardian/designated representative or medical power of attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the Division's AdSS Operations Manual, ACOM Policy 414 and 9 A.A.C. 34.

O. The AdSS shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its Medical Management Program. Data elements shall include but are not limited to:

1. Member demographics;

2. Provider characteristics;

3. Services provided to members; and

4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

P. The AdSS shall oversee and maintain accountability for all functions or responsibilities described in AdSS Chapter 1000 that are delegated to other entities. Documentation shall be kept on file for Division review, and the documentation shall demonstrate and confirm the following requirements have been met for all delegated functions:

1. A written agreement shall be executed that specifies the delegated activities and reporting responsibilities of the entity to the AdSS and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

2. The AdSS shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement shall be submitted the contractor review checklist adopted by the Division and located in the AHCCCS Contractor Operations Manual. Refer ACOM Policy 438.

3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed.

Q. The AdSS shall ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not

structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.

2. Providers are not prohibited from advocating on behalf of members within the service provision process.

1020 UTILIZATION MANAGEMENT

REVISION DATE: 1/25/2023, 7/20/2022, 10/1/2021, 8/4/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. §38-211; A.A.C. R9-201, 42 CFR 435.1010, 438.3, 438.114(a), 438.210, 438.236, 438.240(b)(3), 447.26, 456.125; Section F3, 42 CFR Part 457, and 42 CFR Part 438, Contractor Chart of Deliverables; AMPM Policy 310, AMPM Attachment 1020-A, AMPM Attachment 1020-B

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines utilization management functions provided by the AdSS to ensure effective treatment services and coordination of care are furnished that achieve optimal outcomes for members. The policy also addresses how the AdSS identifies opportunities for improvement in utilization management.

DEFINITIONS

1. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support

Coordination, Care Management does not include the day-to-day duties of service delivery.

2. "Concurrent Review" means the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care (LOC). Reviewers assess the appropriate use of resources, LOC, and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates for Quality Of Care (QOC).

3. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

   a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy;

b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part [42 CFR 438.114(a)]; or

d. Serious physical harm to another individual (for behavioral health conditions)

4. "Health Care Acquired Condition (HCAC)" means a condition that occurs in any inpatient hospital setting and is not present on admission (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions.)

5. "Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment

of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases as specified in 42 CFR 435.1010.

6. "Institutional Setting" means:
   a. A nursing facility as specified in 42 U.S.C. 1396 r(a);
   b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;
   c. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36- 401;
   d. A Behavioral Health Inpatient Facility (BHIF) as specified in A.A.C. R9-10-101; or
   e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.
7. "Inter-Rater Reliability (IRR)" means the process of monitoring and evaluating qualified healthcare professional staff's level of consistency with decision making and adherence to clinical review criteria and standards.

8. "Other Provider-Preventable Condition (OPPC)" means a condition occurring in the inpatient and outpatient health care setting which the Division and AHCCCS has limited to the following:
   a. Surgery on the wrong member,
   b. Wrong surgery on a member, or
   c. Wrong site surgery.

9. "Peer-Reviewed Study" means prior to publication, a medical study that has been subjected to the review of medical experts who:
   a. Have expertise in the subject matter of the study,
   b. Evaluate the science and methodology of the study,
   c. Are selected by the editorial staff of the publication,
   d. Review the study without knowledge of the identity or qualifications of the author, and
   e. Are published in the United States.

10. "Prior Authorization (PA)" means a process by which the AdSS

authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this policy as specified in A.A.C. R9-201, and any applicable contract provisions. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

12. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

13. "Service Plan (SP)" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer recovery and support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

14. “Special Health Care Needs (SHCN)” means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

15. “Subcontracted health plan” means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

16. “Support Coordination” means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

17. “Telehealth” means healthcare services delivered via asynchronous , remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The AdSS shall develop and implement policies and processes to collect, validate, analyze, monitor, and report the Division's enrollment utilization data.

2. On an ongoing basis, the AdSS' Medical Management (MM) Committee shall review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified specific to the Division enrolled members. Evaluation shall include a review of the impact to both service quality and outcome.

3. The MM Committee shall determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address overutilization and underutilization of services shall be integrated throughout the organization. All such strategies shall have measurable

outcomes that are reported in AdSS MM Committee minutes and shared at quarterly Division and AdSS meetings.

B. CONCURRENT REVIEW

1. The AdSS shall have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings.

2. The AdSS shall have procedures for review of medical necessity before a planned institutional admission (pre-certification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

3. The AdSS shall have policies and procedures for the concurrent review process that:
   a. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information shall include, but is not limited to symptoms, diagnostic test results, diagnoses, and required services.
   b. Specify timeframes and frequency for conducting concurrent review and decisions:

i. Authorization for institutional stays that shall have a specified date by which the need for continued stay shall be reviewed based on the expected course of the stay and medical necessity.

ii. Admission reviews shall be conducted within one business day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) (42 CFR 456.125).

c. Provide a process for review that includes, but is not limited to:

i. Necessity of admission and appropriateness of the service setting;

ii. Quality of care;

iii. Length of stay;

iv. Whether services meet the member needs;

v. Denials or reduction in the level of service;

vi. Discharge needs;

vii. Utilization pattern analysis;

viii. Establish a method for the AdSS' participation in the proactive discharge planning of all members in hospital, and institutional settings. The proactive discharge planning process shall demonstrate communication with the Division's support coordinator assigned to the member.

4. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

5. The AdSS' Medical Management Committee shall annually approve the medical criteria used for concurrent review, which shall be adopted from the national standards. Subsequently it shall be approved by the Division's MM Committee. When providing concurrent review, the AdSS shall compare the member's medical information against medical necessity criteria that describe the condition or service.

6. Initial institutional stays shall be based on the AdSS' adopted criteria, the member's specific condition, and the projected

discharge date. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay shall be assigned a next review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member's record.

7. Coordination shall include proactive discharge planning, starting within one day of admission, between all potential payment and care sources and shall continue after completion of the institutional stay.
8. AdSS shall submit the "Contractor Quarterly Showing Report for Inpatient Hospital Services" as specified in Contract.
9. Providers who request authorization for a service shall be notified of the option to request a peer-to-peer discussion with the appropriate AdSS health plan when additional information is requested or when the admission or continued stay is denied. Requests for peer-to-peer review and disposition of the request shall be clearly documented.

C. DISCHARGE PLANNING

1. The AdSS shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services with the Division's Support Coordination.

2. The AdSS shall furnish acute care services to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays while the Division shall furnish any HCBS/LTC services for the member.

3. The intent of the discharge planning policy and procedure is to increase the management of inpatient admissions, improve the coordination of post discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions.

4. The AdSS shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio psychosocial and medical needs of the

member in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

5. The AdSS shall conduct a proactive assessment of discharge needs before admission when feasible.

6. The AdSS shall ensure discharge planning is performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post discharge to ensure a timely, effective, safe, and appropriate discharge.

7. The AdSS staff participating in the discharge planning process shall ensure the member/responsible person, as applicable:
   a. Is involved and participates in the discharge planning process,
   b. Understands the written discharge plan, instructions, and recommendations provided by the facility,
   c. Is provided with resources, referrals, and possible interventions to meet the member's assessed and

anticipated needs after discharge.

8. The AdSS shall allow:

   a. If a covered behavioral health service required after discharge is temporarily unavailable for individuals in an inpatient or residential facility who are discharge-ready, the member may remain in that setting until the service is available.

   b. Care management, intensive outpatient services, support coordination, and/or peer service are available to the member while waiting for the appropriate covered behavioral health service.

9. The support coordinator shall seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.

10. Discharge planning, coordination, and management of care shall include:

    a. Follow-up appointment with the PCP and/or specialist within 7 days;

b. Safe and clinically appropriate placement, and community support services;

c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, TRBHA and other contractors when appropriate;

d. Prescription medications;

e. Medical Equipment;

f. Nursing Services;

g. End-of-Life Care related services such as Advance Care Planning;

h. Practical supports;

i. Hospice;

j. Therapies (within limits for outpatient physical/occupational therapy visits for members 21 years of age and older);

k. Referral to appropriate community resources;

l. Referral to AdSS' Disease Management or Care

Management (if needed);

m. A post discharge follow-up call to the member/responsible person within three business days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed clinical, behavioral, physical health, and social needs;

n. Proactive discharge planning when the AdSS is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The AdSS shall have an Arizona-licensed PA staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training, to apply the AdSS' medical criteria or make coverage decisions. PA is required in certain circumstances.

2. The AdSS shall develop and implement a system that includes at least two modes of delivery for providers to submit PA requests

such as telephone, fax, or electronically through a portal on the AdSS' website.

3. The AdSS shall ensure providers who request authorization for a service are notified that they have the option to request a peer-to-peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS shall coordinate the discussion with the requesting provider when appropriate.
4. The AdSS shall develop and implement policies and procedures, coverage criteria, and processes for approval of covered services, which include required time frames for authorization determination.
5. The AdSS shall have policies and procedures for approval of specified services that:
    a. Identify and communicate to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization shall also

be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS websites, and/or provider manuals. Changes in the coverage criteria shall be communicated to members, TRBHAs, and providers at least 30 days before implementation of the change;

b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria shall be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria shall be available to members upon request;

c. Authorize services in a sufficient amount, duration, and scope to achieve the purpose for which the services are furnished;

d. Ensure consistent application of review criteria by incorporating inter-rater reliability assessments;

e. Specify timeframes for responding to requests for initial

and continuous determinations for standard and expedited authorization requests as defined in, AdSS Operations Manual Policy 414, and 42 CFR 438.210;

f. Provide decisions and notice as expeditiously as the member's health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i);

g. Provide for consultation with the requesting provider when appropriate; and

h. Review all PA requirements for services, items, or medications annually. The review shall be reported through the MM Committee and shall include the rationale for changes made to PA requirements. A summary of the PA requirement changes and the rationale for those changes shall be documented in the MM Committee meeting minutes.

6. The AdSS shall develop and implement policies for processing

and making determinations for PA requests for medications.

7. The AdSS shall ensure the following:

   a. A decision to a submitted PA request for a medication is provided by telephone, fax, electronically, or other telecommunication device within 24 hours of receipt of the submitted request for PA;

   b. A request for additional information is sent to the prescriber by telephone, fax, electronically, or other telecommunication device within 24 hours of the submitted request when the PA request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request;

   c. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)].

8. The AdSS criteria for decisions on coverage and medical

necessity for both physical and behavioral services shall be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

9. The AdSS may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness, or condition of the member.

10. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.

11. The AdSS shall have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS' obligation to render a determination regarding coverage within the timeframes established in this policy.

E. INTER-RATER RELIABILITY

1. The AdSS shall have in place a process to ensure consistent application of review criteria in making medical necessity decisions that include prior authorization, concurrent review, and retrospective review. Inter-rater reliability (IRR) testing of all staff involved in these processes shall be done at orientation and at least annually thereafter. A corrective action plan shall be included for staff that do not meet the minimum compliance goal of 90%.

2. At least annually, the IRR testing results shall be presented to the MM Committee for review and approval.

3. At least annually and upon request, IRR testing results shall be provided to the Division.

F. RETROSPECTIVE REVIEW

1. The AdSS shall conduct a retrospective review, which is guided by policies and procedures that:

a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,

b. List services requiring retrospective review, and

c. Specify time frame(s) for completion of the review.

2. Criteria for decisions on medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

3. The AdSS shall have a process for consistent application of review criteria.

4. Guidelines for Provider-Preventable Conditions:

a. Title 42 CFR Section 447.26 prohibits payment for services related to Provider Preventable Conditions. Provider Preventable Condition means a condition that meets the definition ofHealth Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC);

b. A member's health status may be compromised by hospital

conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC shall not be reimbursed;

c. If it is determined that the HCAC or OPPC was a result of an error by a hospital or medical professional, the AdSS shall conduct a quality of care (QOC) investigation and report it in accordance with AdSS Medical Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The AdSS shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:

   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;

   b. Consider the needs of people with intellectual/developmental disabilities (I/DD) who are

enrolled with the AdSS;

c. Are either:

i. Adopted in consultation with contracting health care professionals and National Practice Standards, or

ii. Developed in consultation with health care professionals and include a thorough review of peer reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

d. Are disseminated by the AdSS to all affected providers and, upon the request, to members/responsible person and potential members; and

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 CFR 438.236).

2. The AdSS shall evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards every two years.
3. The AdSS shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The AdSS shall develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology that include an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals and devices.
2. The AdSS shall have policies and procedures that include the

process and timeframe for making a clinical determination when a time sensitive request is made.

3. The AdSS shall make a decision in response to an expedited request as expeditiously as the member's condition warrants and not later than 72 hours from receipt of request.

4. The AdSS shall include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions in its evaluation.

5. The AdSS shall evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature shall also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

6. The AdSS shall establish:

   a. Coverage rules, practice guidelines, payment policies,

policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met;

b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received;

c. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.

I. MONITORING AND OVERSIGHT

1. The AdSS shall meet with the Division Health Care Services (HCS) quarterly to review the Medical Management Committee minutes, reports with data analysis and action plans, over and under utilization, outliers, and opportunities for performance improvement.

2. Annually the Division shall perform an Operational Review of the AdSS utilization process.

J. SUPPLEMENTAL INFORMATION

1. The AdSS are responsible for the administration of utilization management activities for all contracted services they provide to members served by the Division.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:48 MST)
Anthony Dekker, D.O.

1021 CARE MANAGEMENT

REVISION DATE: 8/30/2023
EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §§ 13-3994; A.R.S. §§ 31-501; A.R.S. §§ 36-551; A.R.S. §§ 38-211; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi); 42 CFR 438.208(b)(2)(ii) and (iii); 42 CFR 438.208(b)(2)(iv); 42 CFR 457.1220; 42 CFR 457.1230(c); 45 CFR Part 160 and 164; AMPM 310-HH; AMPM 520; AMPM 570; AMPM 580; AMPM 940; AMPM 1010; AMPM 1021; AMPM 1620; ACOM 438.

PURPOSE

This policy sets forth roles and responsibilities of the Administrative Services Subcontractors (AdSS) for provision of Care Management services and collaboration with the Division of Developmental Disabilities (Division) to improve health outcomes for Members eligible for ALTCS who may or may not have a chronic disease but have physical or behavioral health needs or risks that require immediate AdSS intervention.

DEFINITIONS

1. “Advance Care Planning” means a part of the End-of-Life Care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the Member to:

a. Educate the Member about their illness and the health care options that are available to them;

b. Share the Member's wishes with family, friends, and his or her physicians.

c. Develop a written plan of care that identifies the Member's choices for treatment;

2. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

3. "Care Management" means a group of activities performed by the AdSS to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day- to-day duties of service delivery.

4. "Care Manager" means someone who provides Care Management services.

5. "End-of-Life Care" means a concept of care, for the duration of the Member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a Member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.

6. "Informal Supports" means non-billable services provided to a Member by a family member, friend, or volunteer to assist or perform functions such as:
   a. Housekeeping,
   b. Personal care,
   c. Food preparation,
   d. Shopping,
   e. Pet care, or
   f. Non-medical comfort measures.

7. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the Services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

10. "Planning Team" means a group of people including the Member; Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff; as necessary; and any person selected by the Member; Responsible Person; or the Department.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

12. "Social Determinants of Health" or "SDOH" means the social, environmental, and economic factors that can influence health status and have an impact on health outcomes.

13. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by Members generally that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP).

14. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

15. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The AdSS shall have in place a Care Management process with the primary purpose of coordinating care and assisting in accessing resources for Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The AdSS shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, provider or the Division.

3. The AdSS shall provide Care Management that is designed to be short-term and time-limited in nature.

4. The AdSS shall require the following Care Management services:
   a. Assistance in making and keeping needed physical or behavioral health appointments;
   b. Following up and explaining hospital discharge instructions;

c. Health coaching and referrals related to the Member's immediate needs;

d. Primary Care Provider (PCP) reconnection; and

e. Offering other resources or materials related to wellness, lifestyle, and prevention.

5. The AdSS shall provide care coordination to ensure Members receive the necessary services to prevent or reduce an adverse health outcome.

6. The AdSS shall ensure that clinical resources and assessment tools utilized are evidenced-based.

7. Care Managers shall establish a process to ensure coordination of Member physical and behavioral health care needs across the continuum, based on early identification of health risk factors or Special Health Care Needs (SHCN) consistent with the Planning Document.

8. The AdSS shall ensure the coordination ensures provision of physical and behavioral services in any setting that meets the

Member's needs in the most cost-effective manner available.

9. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and coordinating care.

10. The AdSS Care Management system shall automatically document the staff member's name and ID and the date and time the action or contact with the Member occurred.

11. The AdSS Care Management system shall also provide automatic prompts and reminders to follow-up with the Member as specified in the Member's care plan.

12. The AdSS shall provide Care Management at the contractor level as an administrative function. The AdSS shall receive prior approval from the Division if the AdSS intends to delegate a portion of Care Management functions.

13. The AdSS shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the Tribal Regional Behavioral Health

Authority (TRBHA) case manager.

14. Care Managers shall work closely with the case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

15. The AdSS shall develop Member selection criteria for the Care Management model to determine the service intensity or targeted interventions a Member may require to help achieve improved health outcomes and reduce risk and cost.

16. The AdSS shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMRs), health services programs within the organization, or other advanced data sources to develop the selection criteria.

17. The AdSS shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. CARE MANAGER RESPONSIBILITIES

1. Care Managers shall comprehensively assess the Member and develop and implement a care plan that has the following:

   a. Initial assessment of Members:

      i. Health status;

      ii. Physical and behavioral health history, including medications and cognitive function;

      iii. Activities of daily living;

      iv. Social Determinants of Health (SDOH).

   b. Life planning activities, including wills, living wills, advance directives, health care powers of attorney, End-of-Life Care and Advance Care Planning.

   c. Evaluation of:

      i. Cultural and linguistic needs and preferences;

      ii. Visual and hearing needs and preferences;

      iii. Caregiver resources; and

      iv. Availability of services, including community

resources.

d. Development of a Care Management plan, including self-management tools, prioritized goals that consider Member and caregiver preferences and desired level of involvement;

e. Identification of barriers;

f. Facilitation of referrals and a follow-up process to determine if Members act on referrals made;

g. Development of a schedule for follow-up and communication with the Member;

h. A process and timeframe for monitoring the effectiveness of Care Management.

2. Care Managers shall work with the Support Coordinator, the provider case manager, AdSS tribal liaison, the Primary Care Physician (PCP) or specialist(s) to coordinate and address Member needs within 30 days after the member has been determined eligible to receive Care Management.

3. Care Managers shall continuously document interventions and changes in the plan of care.

C. AdSS RESPONSIBILITIES

1. The AdSS shall establish policies and procedures that reflect integration of services to ensure continuity of care by:
   a. Ensuring that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements including those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);
   b. Allowing Member choice in selecting a PCP, TRBHA or a behavioral health provider who is formally designated as having primary responsibility for coordinating the Member's overall health care;
   c. Ensuring access to care that is appropriate to their

individual needs as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

d. Ensuring each Member receiving care coordination has an individual or entity that is formally designated as primarily responsible for coordinating services for the Member, such as the Division Support Coordinator, the provider case manager, or TRBHA case manager;

e. Ensuring the Care Manager provides the Responsible Person with information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

f. Specifying under what circumstances services are coordinated by the AdSS, including the methods for coordination and specific documentation of these processes;

g. Coordinating the services for Members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays

as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i);

h. Coordinating covered services with the services the Member receives from another entity or FFS provider as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(ii) and (iii);

i. Coordinating covered services with community and Informal Supports that are generally available through another entity or FFS provider in the Division's service area, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(iv);

j. Ensuring Members receive End-of-Life Care and Advance Care Planning;

k. Ensuring Care Managers establish timely and confidential communication of data and clinical information among providers that includes:

i. The coordination of Member care among the PCP,

AdSS, and tribal entities;

ii. Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division or FFS provider and Tribal provider to include TRBHA when the PCP becomes aware of the Division, or TRBHA involvement in care.

l. Ensuring that the AdSS is providing pertinent diagnoses and changes in condition to the PCP:

i. No later than 30 days from change in medication or diagnosis, or

ii. No later than 7 days of hospitalization.

m. Facilitating this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs;

n. Ensuring Care Managers provide consultation to a Member's inpatient and outpatient treatment team and

directly engages the Member as part of AdSS Care Management;

o. Ensuring individuals admitted to a hospital who are identified as in need of behavioral health services, are responded to as specified below:

   i. Upon notification of an individual who is not currently receiving behavioral health services, the AdSS shall ensure a referral is made to a provider agency within 24 hours.

p. Ensuring that provider agencies attempt to initiate services with the individual within 24 hours of referral and that the provider agency schedules additional appointments and services with the individual prior to discharge from the hospital;

q. Ensuring coordination, transition, and discharge planning activities are completed consistent with providers orders to ensure cost effectiveness and quality of care for Members

already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the AdSS' provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensure access to appropriate services such as Medication Assisted Treatment (MAT) and peer support services;

2. The AdSS shall develop policies and implement procedures for Members with SHCN, as specified in the contract with the Division and AMPM Policy 520, including:

a. Identifying Members with SHCN;

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each Member;

c. Ensuring adequate care coordination among providers or TRBHAs;

d. Ensuring a mechanism to allow direct access to a specialist

as appropriate for the Member's condition and identified needs (e.g., a standing referral or an approved number of visits); and

e. Additional care coordination activities based on the needs of the Member.

3. The AdSS shall implement measures to ensure that the Responsible Person involved in Care Management:

   a. Is informed of particular health care conditions that require follow-up;

   b. Receives, as appropriate, training in self-care and other measures they may take to promote their own health; and

   c. Is informed of their responsibility to comply with prescribed treatments or regimens.

4. The AdSS Care Management shall focus on achieving Member wellness and autonomy through:

   a. Advocacy,

   b. Communication,

c. Education,

d. Identification of service resources, and

e. Service facilitation.

5. The Care Manager shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS providers, and facilities throughout the continuum of services.

6. The Care Manager shall ensure that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the Member and the AdSS.

7. The AdSS shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS Program. This includes Members who do not otherwise meet the Division criteria for Care Management, as well as Members who contact governmental entities for assistance, including AHCCCS.

8. The AdSS shall report its monitoring of Members awaiting admission and those Members who are discharge-ready from

Arizona State Hospital (ASH) utilizing the Arizona State Hospital Admission and Discharge Deliverable Template.

9. The AdSS shall demonstrate proactive care coordination efforts for all Members awaiting admission to, or discharge from ASH.

10. The AdSS shall coordinate with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge.

11. The AdSS shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The AdSS shall submit the following, in the case that a Member has been awaiting admission to, or discharge from ASH for an excess of 90 days:

    a. A barrier analysis report to include findings, performance improvement activities and implementation plan, and

    b. A status report for each Member who is continuing to await admission or discharge as specified in the contract with the

Division.

13. The AdSS shall arrange ongoing medically necessary nursing services consistent with providers orders to ensure cost effectiveness and quality of care in the event that a Member's mental status renders themself incapable or unwilling to manage their medical condition and the Member has a skilled medical need.

14. The AdSS shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

15. The AdSS shall implement interventions to educate the Responsible Person on appropriate use of ED and divert Members to the right care in the appropriate place of service.

16. The AdSS shall ensure Care Management interventions to educate Responsible Persons include:
    a. Outreach phone calls or visits,
    b. Educational letters,

c. Behavioral health referrals,

d. HNHC program referrals,

e. Disease or chronic Care Management referrals,

f. Exclusive pharmacy referrals, or

g. Social Determinants of Health (SDOH) resources.

17. The AdSS shall submit AMPM Attachment 1021-A as specified in the contract with the Division, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

18. The AdSS shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

19. The AdSS shall coordinate care with the ED and the Member's treatment team to discharge the Member to the most appropriate placement or wrap-around services immediately upon notification that a Member who requires behavioral health placement or wrap-around services is in the ED.

20. The AdSS Chief Medical Officer shall be involved when Members experience a delay in discharge from institutional settings or the ED.

21. The AdSS shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with the Division.

22. The AdSS shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the MM Program workplan.

23. The AdSS shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.

24. The AdSS shall report the plan specifying the strategies for improving care coordination and the outcome measurement in the annual MM Program Plan, and submitted as specified in the contract with the Division, utilizing AMPM Policy 1010 Attachment A and Attachment B.

25. The AdSS tribal liaison shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to enrolled American Indian and Alaskan Native Members.
26. The AdSS tribal liaison shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.
27. The AdSS shall meet with the Division HCS quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over and under-utilization, outliers, and opportunities for performance improvement.
28. The AdSS shall coordinate with the Division's Behavioral Health Complex Care Specialist and Support Coordinator to provide assistance with care coordination for Members who are awaiting placement into ASH by communicating with the Responsible Person, Support Coordinator, facilities, providers, and ASH.

D. HIGH NEEDS/HIGH COST (HNHC) PROGRAM

1. The AdSS shall identify, implement, and monitor interventions for providing appropriate and timely care to Members with high needs or high costs who have physical or behavioral health needs.
2. The AdSS shall collaborate with the Division HCS to coordinate care for Members enrolled in the High Needs/High Costs (HNHC) program who have physical or behavioral health needs.
3. The AdSS shall participate in care coordination or interdisciplinary team meetings at least monthly, or more often, as needed, to affect change and if needed to discuss barriers and outcomes.
4. The AdSS shall implement the following:
    a. Planning interventions for addressing appropriate and timely care for the identified Members.
    b. Specifying methodologies, inclusion criteria, interventions, and Member outcomes based on data analysis; and
    c. Utilizing additional criteria if the AdSS determines it necessary.

5. The AdSS shall submit an overview of the HNHC program, which shall include the requirements in section (D), in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A.
6. The AdSS shall submit counts of distinct Members that are considered to have high cost behavioral health needs based on criteria developed by the AdSS and approved by the Division.
7. The AdSS shall submit the High-Cost Behavioral Health Report on AMPM Attachment 1021-E as specified in the contract with the Division.
8. The AdSS Care Management program for HNHC Members shall incorporate a stratification approach to differentiate levels of Care Management provided based on factors such as:
    a. The severity of the conditions;
    b. Complexity of treatment coordination needs;
    c. Presence of co-occurring substance use or mental health conditions;
    d. Health or safety risks;

e. Inpatient or ED utilization;

f. Poly-Pharmacy;

g. Functional deficits; and

h. Involvement with other Member-serving systems.

9. The AdSS shall provide in their proposed stratification methodology the appropriate levels of Care Management necessary to ensure health, welfare and safety for Members and should consider such factors as:

a. Caseload mix;

b. Member acuity and coordination needs; and

c. Care Manager qualifications, experience and responsibilities.

10. The AdSS shall ensure the Care Management program for High Need/High Cost Members has prior approval of the Division. Material changes to a Division-approved Care Management program must be approved in advance by the Division.

11. The AdSS shall develop and implement policies and procedures related to the AdSS Care Management program for HNHC

Members to ensure the active coordination of integrated physical and behavioral health services with Long Term Support Services (LTSS), in collaboration with the Support Coordinator for HNHC Members.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:01 PDT)
Anthony Dekker, D.O.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: January 18, 2023

REFERENCES: 42 CFR § 438.62(b); A.R.S.§ 36-551; AMPM 1022; AMPM 541

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop a process for justice system reach-in care coordination activities, to support facilitating transition of members who have chronic and/or complex care needs out of jails and prisons, into communities.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means a person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.
2. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to

reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

3. "Justice System Liaison" for the purpose of this policy means a Division staff person who is located in Arizona and is the single point of contact for justice system stakeholders, such as jails/prisons/detention facilities, courts, law enforcement, and community supervision agencies. This position is responsible for ensuring care coordination of justice-involved members and for oversight and reporting of Justice System reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system. This includes, but is not limited to, sequential intercept modeling, crisis system utilization, and

specialty court programs.

POLICY

A. JUSTICE REACH-IN

1. Administrative Services Subcontractors shall notify the Division's Justice System Liaison, upon becoming aware that a Division member has become an inmate of a public institution.

2. The AdSS shall assist the Justice System Liaison in reach-in care coordination efforts, for members who have been incarcerated for 20 days or longer and have an anticipated release date.

3. The AdSS shall establish care management protocols for members involved in reach-in care coordination, which include but are not limited to members who have substance abuse disorder and/or meet medical necessity criteria to receive Medication Assisted Treatment (MAT), as consistent with AMPM 1022.

4. The AdSS shall notify the Division upon becoming aware that the incarcerated member's enrollment has not been suspended

to allow the Division to adjust eligibility dates, based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division.

5. The AdSS shall also utilize the renewal date information to identify incarcerated members who may have missed their eligibility redetermination dates while incarcerated causing a discontinuance of benefits, and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

6. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) to provide care management to members

7. The AdSS shall begin reach-In care activities upon knowledge of a member's anticipated release date and shall include education regarding care, services, resources, appointment information, subcontracted provider and care management contact information.

8. The AdSS shall monitor progress and submit a monitoring

progress report throughout the year as specified in the current Contract.

Signature of Chief Medical Officer: Anthony Dekker (Feb 14, 2023 15:09 MST)

Anthony Dekker, D.O.

1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551; AMPM 1023

PURPOSE

This policy outlines the requirements for the Division of Developmental Disabilities (Division) Disease/Chronic Care Management Program. The program focuses on members with chronic conditions, and/or at high risk, and may benefit from a targeted intervention plan.

DEFINITIONS

1. "Care Management" means a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

2. "Case Management" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Case Management

for DES/DDD is referred to as support coordination.

3. "Disease/Chronic Intervention Plan" means a protocol targeted at managing a disease/chronic condition and improving health outcomes.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

5. "Person Centered Service Plan" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

POLICY

The Division Disease/Chronic Care Management Program focuses on members with high need/high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The Disease/Chronic Care Management Program shall develop individualized intervention plans that include early identification of potential members, coordination of treatment, and chronic disease management strategies including education and self-management of conditions. The program shall work with Support Coordination, and the Administrative Services Subcontractors (AdSS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment.

A. CRITERIA FOR ENROLLMENT

A member is eligible for the program who:

1. Has been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;

2. Is identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;

3. Has one or more of the Fatal Five (aspiration; bowel obstruction, gastroesophageal reflux disease [GERD], dehydration, or seizures) conditions considered preventable causes of death in people with intellectual/developmental disabilities;

4. Has been diagnosed with post- Covid-19 condition(s); or

5. Has exhibited high or low utilization of services for high need conditions.

B. PROGRAM COMPONENTS

The Disease/Chronic Care Management Program provides a focused assessment of opportunities and development of an intervention plan to better manage disease or conditions for targeted members, improve health outcomes and quality of life.

Program activities include:

1. Screenings and assessments to identify high risk behaviors or emerging health issues, coordination of treatment, as appropriate, with the AdSS including but not limited to:

   a. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for qualified members, including

education and health promotion for dental/oral health services

b. Substance use

c. Depression

d. Tobacco use

2. Development of an individualized Disease/Chronic Condition Intervention Plan that involves working closely with the member and/or responsible person and obtaining their agreement with the plan. The plan includes the following components:

a. Goals.

b. Opportunities, interventions and resources to improve long term health outcomes.

c. Coordination with primary care provider/specialty care provider(s) and medical/behavioral treatment teams.

d. Regular contact by Health Care Services with the member and/or responsible person.

e. Evidence-based guidelines to enhance the health, wellness and quality of life of the member while reducing

the need for hospitalization and other costly treatments. Individualized targeted interventions designed to improve and sustain member engagement in treatment.

f. Actions to be taken by the member and/or responsible person.

g. Health education, resources and support tailored to the member's needs, including but not limited to:

i. Understanding chronic disease/conditions and improving health, wellness and quality of life

ii. Working with the care team, treatment/ services providers and allied supports

iii. Establishing and maintaining treatment relationships that foster consistent and timely interventions

iv. Understanding the member role in health and wellness

v. Healthy living and wellness programs

vi. Self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/ chronic conditions

vii. Health risk-reduction and healthy lifestyle choices, including tobacco cessation.

viii. Preventative care may include but is not limited to:

1) Health screening

2) Annual health exams

3) Cancer screening

4) Dental/oral health services.

5) OB/Gyn care

6) Maternity care programs and services for pregnant women.

3. Engagement, ongoing support and technical assistance with Support Coordination and the AdSS to integrate the Disease/Chronic Condition Intervention Plan into the person-centered service plan to support sustainability and continuity of care.

4. Once the health care services team determines the member to be ready for discharge, the member may be discharged from the disease/chronic care program. The Team is available for technical assistance and consultation to Support Coordination

and/or the AdSS to support the transition.

5. The member may be re enrolled based on the recommendation of Support Coordination, the AdSS and/or identified through HCS utilization reviews/reports.

C. OVERSIGHT

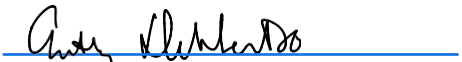
1. The Division collaborates with the AdSS to evaluate the effectiveness of the program by assessing the members' ability to self-manage their condition/disease and measuring other outcomes at predetermined points after enrollment. Other outcomes may include cost/utilization of services, clinical quality, and process measures.

2. The Division works in partnership with the AdSS to educate providers regarding the specific evidenced-based guidelines and desired outcomes of the program. The AdSS staff and providers may participate in the development of the Division specific evidence-based guidelines.

3. The Division monitors the AdSS to ensure provider compliance with the member Disease/Chronic Condition Intervention Plan and that appropriate corrective action is taken for any noncompliance.

4. Health Care Services shall track and trend performance metrics and outcomes identifying successful interventions and provide reports to the Division Medical Management Committee.

5. At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of the Disease/Chronic Care Management Program compliance.

Signature of Chief Medical Officer: 
Anthony Dekker (Jul 11, 2022 14:17 PDT)
Anthony Dekker, D.O.

1024 DRUG UTILIZATION REVIEW

REVISION DATE: 3/27/2024
REVIEW DATE: 6/27/2023
EFFECTIVE DATE: July 13, 2022
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, 42 U.S.C 1396r-8 and A.A.C. R9-22-209, 42 USC 1396A(OO), Social Security Act Section 1927 (g) Drug Use Review, AHCCCS Contract, AMPM 310-FF, AMPM 310-V, AMPM 1024.

PURPOSE

This policy outlines the AdSS's responsibility for developing and implementing a Drug Utilization Review (DUR) process that includes retrospective, concurrent and prospective drug utilization edits.

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division.

2. "Drug Utilization Review" or "DUR" means a systematic, ongoing review of the prescribing, dispensing, and use of medications. The purpose is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve Member health status and quality of care.

3. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the AdSS to provide all medically necessary Federal and State reimbursable drugs to the Member.

4. "Exclusive Provider" means an individual provider, which is chosen by the Member or assigned by the AdSS to provide all medically necessary Federal and State reimbursable drugs to the Member.

5. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes Fraud under applicable

State or Federal law.

6. "Prescription Drugs" means prescription medications prescribed by an Arizona Health Care Cost Containment System (AHCCCS) registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and State laws.

7. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. DRUG UTILIZATION REVIEW REQUIREMENTS

1. The AdSS shall report the following to the Division:
    a. Concurrent Drug Utilization Review (DUR);
    b. Opioid monitoring;
    c. Antipsychotic prescribing in children; and

d. Identification of Fraud, Waste, and Abuse by either DDD Members or health care practitioners.

2. The AdSS shall perform DUR to ensure that Members are receiving medications appropriately with limited adverse drug reactions.

3. The AdSS shall perform DUR that consists of retrospective, concurrent and prospective DUR.

4. The AdSS shall use Arizona Health Care Cost Containment System (AHCCCS) Prior Authorization (PA) clinical guidelines.

5. The AdSS shall base opioid monitoring per Federal regulations.

B. CONCURRENT UTILIZATION REVIEW

1. The AdSS shall implement a concurrent DUR process that occurs between the pharmacies and Pharmacy Benefits Manager's (PBM) electronic DUR system at the Point of Sale (POS).

2. The AdSS shall provide concurrent DUR edits that include:

a. Preferred and non-preferred Federally and State reimbursable drugs prior to dispensing;

b. Drug-drug interactions;

c. Excessive doses;

d. High and suboptimal doses;

e. Over and underutilization;

f. Drug-pregnancy precautions;

g. Drug-disease interactions;

h. Duplicate therapy; and

i. Drug-age precautions.

C. RETROSPECTIVE UTILIZATION REVIEW

1. The AdSS shall implement a retrospective DUR process to detect aberrant prescribing practice patterns, pharmacy dispensing patterns and medication administration patterns to prevent inappropriate use, misuse, or Waste.

2. The AdSS shall perform retrospective utilization reviews to

evaluate the following edits:

a. Clinical appropriateness, use and misuse;

b. Appropriate generic use;

c. Drug-drug interactions;

d. Drug-disease contraindications;

e. Aberrant drug doses;

f. Inappropriate treatment duration;

g. Member utilization for over and underutilization;

h. Prescriber clinician prescriptive ordering and practice patterns; and

i. Pharmacy dispensing patterns.

D. PROSPECTIVE UTILIZATION REVIEW

1. The AdSS shall implement a prospective DUR process that promotes positive health outcomes using PA to ensure clinically effective medications are prescribed in the most cost-efficient manner.

2. The AdSS shall require the PBM to enable prospective DUR edits during the adjudication of a claim for the following:
    a. Drug-allergy interactions;
    b. Drug-disease contraindications;
    c. Therapeutic interchange;
    d. Generic substitution;
    e. Incorrect drug doses;
    f. Inappropriate duration of drug therapy;
    g. Medication Abuse or misuse; and
    h. Medications preferred on the AHCCCS Drug List.

E. PRIOR AUTHORIZATION (PA) CLINICAL GUIDELINES

The AdSS shall utilize the AHCCCS PA guidelines for any medications that require PA, have quantity limits or step therapy requirements or are non-preferred medications.

F. PROVIDER EDUCATIONAL INTERVENTIONS

The AdSS shall have educational interventions based on evaluations of practice patterns focused on drug therapy outcomes with the aim of improving safety, prescribing practices and therapeutic outcomes and ensuring the interventions improve quality of care.

G. EXCLUSIVE PHARMACY OR EXCLUSIVE PROVIDER PROGRAM

1. The AdSS shall report Members assigned to an Exclusive Pharmacy or Exclusive Provider, or both on form AMPM 1024 Attachment A.

2. The AdSS shall provide AMPM 1024 Attachment A to the Division as a quarterly deliverable when aberrant pharmacy or aberrant provider utilization is identified.

H. OPIOID UTILIZATION

1. The AdSS shall perform DUR activities as part of Federal Opioid Legislation, and report to the Division in accordance with the Centers for Medicare and Medicaid Services (CMS) DUR

requirements as specified in the Contract for the following:

a. Opioid utilization and concomitant use of benzodiazepines;

b. Opioid utilization and concomitant use of antipsychotics;

c. Buprenorphine utilization and concomitant use of opioids;

d. 7-day limits for opioid naïve adults;

e. 5-day limits for opioid naïve minors;

f. 50 Morphine Equivalent Daily Dose (MEDD) limits for opioid naïve Members;

g. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90;

h. Antipsychotic prescribing for children; and

i. Fraud, Waste and Abuse by Members, pharmacies, and prescribing clinicians.

2. The AdSS shall exclude Members with a diagnosis of cancer, in hospice or palliative care from opioid safety edits and utilization

management limitations associated with opioids.

Signature of Chief Medical Officer: Anthony Dekker (Mar 21, 2024 09:29 PDT)

Anthony Dekker, D.O.

1040 OUTREACH, ENGAGEMENT, AND RE-ENGAGEMENT FOR BEHAVIORAL HEALTH

EFFECTIVE DATE: October 28, 2020
REFERENCES: AMPM Policy 320-R, AMPM Policy 320-U

Overview

This policy establishes requirements of the Division of Developmental Disabilities (Division) for the outreach, engagement, and reengagement activities for members seeking and receiving behavioral health services by each Administrative Services Subcontractor (AdSS).Each AdSS must develop and make available to providers its policies and procedures regarding outreach, engagement, and reengagement, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Definitions

Engagement - For purposes of this policy, the establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness, and warmth.

Outreach activities - For purposes of this policy, activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services.

Reengagement - For purposes of this policy, activities by providers designed to encourage the individual to continue participating in services.

Policy

The AdSS will incorporate the following critical activities regarding service delivery within the AHCCCS System of Care:

A. Establish expectations for the engagement of members seeking or receiving behavioral health services,

B. Determine procedures to reengage members who have withdrawn from participation in the behavioral health treatment process,

C. Describe conditions necessary to end reengagement activities for members who have withdrawn from participation in the treatment process, and

D. Determine procedures to minimize barriers for serving members who are attempting to reengage with behavioral health services.

Community Outreach

The AdSS will provide and participate in community outreach activities to inform members of the benefits and availability of behavioral health services and how to access them. Outreach activities conducted by the AdSS may include the following:

A. Participation in local health fairs or health promotion activities;

B. Involvement with local schools;

C. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events;

D. Development of outreach programs and activities for first responders (i.e. police, fire, EMT);

E. Development of outreach programs to members experiencing homelessness;

F. Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;

G. Publication and distribution of informational materials;

H. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs;

I. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers;

J. Development and implementation of outreach programs to identify members with co-morbid medical and behavioral health disorders and those who have been determined to have Serious Mental Illness (SMI) within the Contractor's geographic service area; including persons who reside in jails, homeless shelters, county detention facilities or other settings;

K. Provision of information to behavioral health advocacy organizations; and

L. Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Behavioral health providers shall participate in engagement, reengagement, and follow-up processes as described in this policy.

Engagement

The AdSS must ensure active engagement by providers in the treatment planning process with the following:

A. The member and/or member's legal guardian;

B. The member's family or significant others, if applicable and amenable to the person;

C. Other agencies or providers, as applicable; and

D. For persons with a SMI who are receiving Special Assistance (see AMPM Policy 320-R), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Reengagement

The AdSS must ensure reengagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services, or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to reengage members must be documented in the member's file.

A. The behavioral health provider shall attempt to reengage the member by:

1. Communicating in the member's preferred language.

2. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g. after work or school).

3. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk.

4. Sending a letter to the current or most recent address requesting contact if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

5. Contacting the person designated to provide Special Assistance for his/her involvement in reengagement efforts for members determined to have a SMI who are receiving Special Assistance (see AMPM Policy 320-R).

B. If attempts to engage the member are unsuccessful, the Support Coordinator must ensure further attempts are made to re-engage the member. Further attempts must include at a minimum, contacting the member or member's responsible person face-to-face and contacting natural supports for whom the member has given permission to contact. All attempts to reengage members must be clearly documented in the member's case file.

C. If face-to-face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled, or gravely disabled, the Support Coordinator must determine whether it is appropriate to engage the person to seek inpatient care voluntarily. If the member declines

voluntary admission, the Support Coordinator must initiate the pre-petition screening or petition for treatment process described in AMPM Policy 320-U.

Follow-up After Significant and/or Critical Events

Discharge planning must begin upon notification that the member has been hospitalized. The AdSS must ensure activities are documented in the member's case file and follow-up activities are conducted to maintain engagement within the following timeframes.

The Division has District Nurses available to assist as considered beneficial to optimally meeting the needs of the individual member during their care transition:

A. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;

B. Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;

C. Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and

D. Changes in the level of care.

1050 RESERVED

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 01, 2019

1060 RESERVED

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 1, 2019

1210 INSTITUTIONAL SERVICES AND SETTINGS

EFFECTIVE DATE: October 1, 2019

This policy applies to AdSS and its contractors. The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS). Institutional settings include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), Inpatient Behavioral Health Residential Treatment Facilities and Nursing Facility (NF) Services.

AdSS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. For purposes of this Service Specification, the term "Contractor" refers to the facility.

Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

Nursing Facility

See Chapter 310-R of this manual regarding acute NF Services for members who are ALTCS eligible and members in the ALTCS transitional program.

Service Description and Goals

This service provides habilitative skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/Medicaid certified.

Contractor Requirements

The Contractor must:

A. Be licensed and certified by the appropriate Arizona state agencies.

B. Comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 *et seq*.

C. Comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

E. Provide all services in a culturally relevant and linguistically appropriate manner for the population to be served.

F. Provide services to members who meet the eligibility requirements for such services as determined by the AdSS and who have been evaluated and placed by the AdSS in coordination with the Division.

G. Provide a healthy, safe, and clean environment that meets the medical, physical, and emotional needs of the member.

H. Provide services, equipment, and supplies as specified in A.A.C. R9-28-204(B), as may be amended.

I. Responsible for coordinating the delivery of the auxiliary services specified in A.A.C. R9-28-204(C), as may be amended.

J. Maintain a complete file for each member that includes physician's orders, care plans, treatment records, medication records, evaluations and assessments, progress reports and any other needed documentation. The member's file must be made available to the AdSS immediately, or as specified by the Division.

K. Ensure that a PASRR Level I assessment is completed on members prior to admission and whenever a significant change in the physical or mental status of the member occurs.

1. Failure to have the proper PASRR screening on file, prior to placement of a member in a Skilled Nursing Facility may result in federal financial participation (FFP) withheld from AHCCCS. If withholding of FFP occurs, the Division will recoup the withheld amount from the AdSS's subsequent capitation payment. The AdSS may, at its option, recoup the withholding from the Contractor that admitted the member without the proper PASRR.

2. Ensure that the completed PASRR Level I is maintained in the member's file, and appropriate referrals made, as needed.

3. If there are indications that a member may have a cognitive/intellectual disability or a related diagnosis, forward the completed PASRR Level I and all supporting documentation, including Minimum Data Set (MDS), health and progress notes, assessments, or other supporting documentation to the AdSS, who is responsible to forward the submitted documents to the Division's Health Care Services Representative (i.e., the PASRR Coordinator). The Division is responsible for completing PASRR Level II reviews.

L. PASRR Level II reviews must occur for each member whose expected stay in the Skilled Nursing Facility will exceed 90 days.

1. If the results of a PASRR Level II review indicate there is a change in the member's condition, ensure:

    a. Recommendations are followed,

    b. Appropriate referrals are made, as needed, and

    c. The Division's Health Care Services representative (e.g., the PASRR Coordinator) is contacted for prior approval before billing a different level of care.

    d. Ensure that any subsequent documentation (e.g., PASRR Level II) is maintained in the member's file.

M. Complete a quarterly review of the member to assess key indicators or resident status and revise the plan of care as necessary.

N. Conduct a reassessment within one year or whenever there is a significant change in the member's status.

O. Provide medical, physical, and emotional care and supervision as follows:

1. Provide nursing care treatment as indicated in the prescribed care plan. The care plan must be specific to the member and be available immediately or as specified by the AdSS.

2. Provide dietary management, including the preparation and administration of special diets and adaptive mealtime equipment.

3. Provide access to dental care and treatment, in accordance with Chapter 300 of the Division's Medical Policy Manual.

4. Provide access to podiatric care and treatment, in accordance with Chapter 300 of the Division's Medical Policy Manual.

5. Provide activities (e.g., therapeutic, vocational), recreational services, and spiritual services in accordance with the member's preference.

6. Provide coordination of services to the member from various agencies, as appropriate. Maintain records of interactions with other agencies or service providers relative to the member.

7. Participate in the development and review of the member's planning document (e.g., Individual Support Plan, Individualized Family Services Plan).

8. Participate in discharge planning following the process specified in the Division's Policy Manuals, as may be amended.

9. Provide an outcome measurement system whereby the member/member's representative can provide feedback regarding satisfaction with the performance of the Contractor. The outcome measurement system must be made available to the AdSS upon request.

P. Provide Progress Reports on the member's planning document (e.g., ISP) objectives every thirty (30) days to the designated Support Coordinator

Contractor Qualifications

A. Skilled Nursing Facility(s) must be licensed by the Arizona Department of Health Services (ADHS) and Medicare/Medicaid certified in accordance with 42 C.F.R. § 483, as may be amended.

B. Skilled Nursing Facility(s) must be is licensed, certified, and monitored in accordance with A.R.S. Title 6, Chapter 4, as may be amended.

C. Skilled Nursing Facility(s) must be registered with AHCCCS to provide this service for that portion of the facility subject to Title XIX (Medicaid) reimbursement.

D. Comply with all applicable federal and state laws relating to professional conditions, standards and requirements for nursing facilities, and all health, safety and physical plant requirements established by federal and state laws.

E. Have procedures that ensure temporary nursing care registry personnel, including Nurses' Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R. § 483.75(e)3 and (g)2 and fingerprinted as required by A.R.S. § 36-411, as may be amended.

F. Maintain on-site files that document appropriate licenses and inspections. Files must be made available to the AdSS immediately upon request or as specified by the AdSS.

Admission Criteria (Nursing Facility)

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40 and a less restrictive level of care is not aviable in a home and community case service setting as determined by the member's planning team.

B. The AdSS must contact the Division by Day 45 of a member's acute NF placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in this chapter, the AdSS must obtain approval from the Division. The Division will use an acuity tool will determine the level of institutional placement prior to placement. If the Primary Care Provider (PCP) or the Division advises that the NF cannot meet the member's needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

C. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:

1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists

2. Daily skilled services that can only be provided in an NF, on an inpatient basis

3. Skilled services because of special medical complications

4. Services that are above the level of room and board.

Reassessment for Continued Placement

A. Members residing in an NF must be reassessed by the AdSS for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).

B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.

C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated by the AdSS when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met and alternative placement has been identified. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to allow the support coordinator to update the current Planning Document to include:

1. The member's health and abilities

2. Current medication

3. Identification of needed Durable Medical Equipment (DME)

4. An updated Service Plan

5. A completed Cost Effectiveness Study (CES) based on anticipated service needs

6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division's Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member's previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division's Medical Director shall resolve disagreements regarding discharge planning.

E. The Division's Chief Medical Officer has the final authority as delegated by the Assistant Director.

NF Contract Termination

If the AdSS places an NF on termination status:

A. No new members will be admitted to the NF.

B. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must include the Division's support coordinator and must identify contracted residential alternatives that are available to the member.

Behavioral Health

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

Behavioral Health Inpatient Facility

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

Institution for Mental Disease (IMD)

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit

B. Medical/acute care services as specified in this Policy Manual.

1240-D EMERGENCY ALERT SYSTEM

REVISION DATE: 02/22/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM 1240-D; Division Medical Policy 1240-D

PURPOSE

This policy establishes the requirements for Administrative Services Subcontractors (AdSS) in the management of Emergency Alert Systems for Members enrolled in AdSS health plans.

DEFINITIONS

1. "Emergency Alert System" or "EAS" means a service that provides monitoring devices or systems for members who are unable to access assistance in an emergency or live alone or would be alone for intermittent periods of time without contact with a service provider, family member, or other support systems, putting the member at risk.
2. "Member" means the same as "client" as defined in A.R.S. § 36-551.

POLICY

A. The AdSS shall offer and make available EAS to Members who meet all

of the following criteria:

1. The Member lives alone or is alone for intermittent periods of time without contact with a service provider, family member, or other support system;
2. The Member's community does not have reliable or available emergency assistance on a 24-hour basis;
3. The assessment of the Member's medical or functional level documents an acute or chronic medical condition;
4. The primary care provider has prescribed the EAS;
5. The Member has the ability to use and operate the system; and
6. If the Member lives in an alternative HCBS setting, the need is justified by the Member's support coordinator.

Signature of Chief Medical Officer: Anthony Dekker (Feb 15, 2023 12:14 MST)
Anthony Dekker, D.O.

1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS AMPM 310-X, Attachment A

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division covers occupational, physical, respiratory and speech therapy services that are ordered by a Primary Care Provider (PCP), approved by the Division or AdSS, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this policy. The AdSS is responsible for providing rehabilitative therapy and habilitative physical therapy services for members Age 21 and older.

Members residing in their own home, and HCB approved alternative residential setting or an institutional setting may receive physical, occupational and speech therapies through a licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational, or speech therapist in independent practice, as applicable.

Services require a PCP or attending physician's order and must be included in the member's record. The record must be reviewed at least every 62 days (bi-monthly) by the member's PCP or attending physician.

Therapy services must be prescribed by the member's PCP or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member's physician for reasonable and necessary treatment of a member's illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposed of the Policy, reasonable and necessary means:

A. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member's condition.

B. Based on the amount, frequency, and duration of the services must be reasonable.

Developmental/Restorative Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member's illness or injury. If the member's expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.

Maintenance Program

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member's condition has been assessed, and the member's caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Division Medical Manual Chapter 300 for additional information regarding therapy services.

Habilitative Therapy

Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may use direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical and Speech Therapy

Therapy Descriptions (Occupational, Physical and Speech)

A. Physical Therapy

The Division covers inpatient and outpatient Physical Therapy (PT) services to members eligible for the Division and ALTCS. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members. Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

B. Occupational Therapy

The Division covers inpatient and outpatient occupational therapy for members eligible for the Division and ALTCS to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process.

C. Speech Therapy

The Division covers inpatient and outpatient speech therapy services including evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with swallowing.

Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills

B. Development of home programs and consultative oversight with the member, family and other providers

C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety

D. Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes

E. Collaboration with all team members/professionals involved in the member's life.

Responsible Person's Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions.

B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills

B. Medical conditions

C. Member's network of support (e.g., family/caregivers, friends, providers)

D. Age

E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy must be provided in settings that support outcomes developed by the team. This includes:

A. The member's home

B. Community settings

C. Division funded settings such as day programs and residential settings for the purpose of training staff

D. Daycare

E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to, the following:

A. Limits as specified in AHCCCS AMPM 310-X, Attachment A – AHCCCS Adult Member (Persons Age 21 and Older) Therapy Benefit Table

B. Therapy for educational purposes.

Respiratory Therapy

The Division covers respiratory care services prescribed by a PCP or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions.

B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's

Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider must be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:

1. Conducting an assessment and/or review previous assessments, including the need for special equipment

2. Developing treatment plans after discussing assessments with the Primary Care Provider, Nurse and the Planning Team

3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member's treatment plan

4. Monitoring and reassessing the member's needs on a regular basis

5. Providing written reports to the AdSS staff, as requested

6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff

7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals

8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment

9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state- operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy must not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) must review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor must review the plan of care at least every 60 days.

C. The provider must submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in any of the following situations:

A. The physician determines that the service is no longer needed as documented on the "Plan of Care."

B. The member/responsible person declines the service.

C. The member moves out of state.

D. The member requires other services, such as home nursing.

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists must collaborate with other service providers and agencies involved with the member.